Mass General Brigham
Health Plan

2024 Prior Authorization Medical Necessity Guidelines

Effective: March 1, 2024
Updated: March 1, 2024

These guidelines were updated on March 1, 2024. For more recent information or other questions, please contact Mass General Brigham Health Plan Customer Service team. Visit **MassGeneralBrighamAdvantage.org/Rx-information** for the most up-to-date information on Medicare Part D drug coverage.

You can reach our Customer Service team
by calling: **855-833-3668** (TTY: 711)

October 1 – March 31
8:00 AM to 8:00 PM EST, Monday through Sunday

April 1 – September 30
8:00 AM to 8:00 PM EST, Monday through Friday

Mass General Brigham Advantage Secure (HMO-POS)
Mass General Brigham Advantage (PPO),
and Mass General Brigham Advantage Premier (PPO)

Mass General Brigham Health Plan is a Medicare Advantage organization with a Medicare contract offering HMO-POS and PPO plans. Enrollment in Mass General Brigham Health Plan depends on contract renewal.

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PA Criteria

Prior Authorization Group	ABIRATERONE
Drug Names	ABIRATERONE ACETATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Node-positive (N1), non-metastatic (M0) prostate cancer and very-high-risk prostate cancer.
Exclusion Criteria	-
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ADEMPAS
Drug Names	ADEMPAS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): 1) Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR 2) Patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ADLARITY
Drug Names	ADLARITY
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Vascular dementia
Exclusion Criteria	-
Required Medical Information	Patient is unable to take oral dosage forms (e.g., difficulty swallowing tablets or capsules). For dementia of the Alzheimer's type: the patient has experienced an inadequate response, intolerance, or the patient has a contraindication to rivastigmine transdermal patch.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AEMCOLO
Drug Names	AEMCOLO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Must have a documented diagnosis of Traveler's diarrhea.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AIMOVIG
Drug Names	AIMOVIG
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the preventive treatment of migraine, initial: 1) The patient experienced an inadequate treatment response with a 4-week trial of any one of the following: antiepileptic drugs (AEDs), beta-adrenergic blocking agents, antidepressants OR 2) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any one of the following: antiepileptic drugs (AEDs), beta-adrenergic blocking agents, antidepressants. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 3 months, Continuation: Plan Year
Other Criteria	-

Prior Authorization Group	AKEEGA
Drug Names	AKEEGA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ALECENSA
Drug Names	ALECENSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent ALK-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC, ALK-positive anaplastic large-cell lymphoma.
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): the disease is recurrent, advanced, or metastatic.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ALPHA1-PROTEINASE INHIBITOR
Drug Names	ARALAST NP, PROLASTIN-C, ZEMAIRA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For alpha1-proteinase inhibitor deficiency: Patient must have 1) clinically evident emphysema, AND 2) pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ALUNBRIG
Drug Names	ALUNBRIG
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC, inflammatory myofibroblastic tumors (IMT) with ALK translocation.
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic AND 2) the disease is anaplastic lymphoma kinase (ALK)-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AMBRISENTAN
Drug Names	AMBRISENTAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ARCALYST
Drug Names	ARCALYST
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Prevention of gout flares in patients initiating or continuing urate-lowering therapy.
Exclusion Criteria	-
Required Medical Information	For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance, or contraindication to maximum tolerated doses of a non-steroidal anti-inflammatory drug (NSAID) and colchicine, AND 3) concurrent use with urate-lowering therapy. For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (continuation): 1) patient must have achieved or maintained a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug. For recurrent pericarditis: patient must have had an inadequate response, intolerance, or contraindication to maximum tolerated doses of an NSAID and colchicine.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ARIKAYCE
Drug Names	ARIKAYCE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ARMODAFINIL
Drug Names	ARMODAFINIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For excessive sleepiness associated with narcolepsy: The diagnosis has been confirmed by sleep lab evaluation. For excessive sleepiness associated with obstructive sleep apnea (OSA): The diagnosis has been confirmed by polysomnography.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AUGTYRO
Drug Names	AUGTYRO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AURYXIA
Drug Names	AURYXIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug is not being prescribed for treatment of iron deficiency anemia in adult patients with chronic kidney disease not on dialysis.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AUSTEDO
Drug Names	AUSTEDO, AUSTEDO XR, AUSTEDO XR PATIENT TITRAT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Tourette's syndrome
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	AYVAKIT
Drug Names	AYVAKIT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myeloid and lymphoid neoplasms with eosinophilia, gastrointestinal stromal tumor (GIST) for unresectable, recurrent, or metastatic disease without platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation.
Exclusion Criteria	-
Required Medical Information	For myeloid and lymphoid neoplasms with eosinophilia, the patient meets all of the following criteria: 1) The disease is FIP1L1- PDGFRA rearrangement-positive, AND 2) The disease harbors a PDGFRA D842A mutation, AND 3) The disease is resistant to imatinib. For GIST, the patient meets either of the following criteria: 1) The disease harbors PDGFRA exon 18 mutation, including PDGFRA D842V mutations, OR 2) The requested drug will be used after failure on at least two Food and Drug Administration (FDA)-approved therapies in unresectable, recurrent, or metastatic disease without PDGFRA exon 18 mutation. For systemic mastocytosis: 1) The patient has a diagnosis of indolent systemic mastocytosis or advanced systemic mastocytosis (including aggressive systemic mastocytosis [ASM], systemic mastocytosis with associated hematological neoplasm [SM-AHN], and mast cell leukemia [MCL]) AND 2) The patient has a platelet count of greater than or equal to 50,000/microliter (mcL).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	B VS. D
Drug Names	ACETYLCYSTEINE, ALBUTEROL SULFATE, AMINOSYN II, AMINOSYN-PF 7%, APREPITANT, ARFORMOTEROL TARTRATE, ASTAGRAF XL, AZATHIOPRINE, BENDEKA, BIVIGAM, BUDESONIDE, CARBOPLATIN, CISPLATIN, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINISOL SF 15%, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOPHOSPHAMIDE MONOHYDR, CYCLOSPORINE, CYCLOSPORINE MODIFIED, DOXORUBICIN HYDROCHLORIDE, DRONABINOL, EMEND, ENGERIX-B, ENVARSUS XR, EVEROLIMUS, FLEBOGAMMA DIF, FORMOTEROL FUMARATE, FREAMINE III, GAMASTAN, GAMMAGARD LIQUID, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, GENGRAF, GRANISETRON HYDROCHLORIDE, HEPLISAV-B, IMOVAX RABIES (H.D.C.V.), INTRALIPID, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, LEVALBUTEROL, LEVALBUTEROL HCL, LEVALBUTEROL HYDROCHLORID, LEVOCARNITINE, METHOTREXATE, METHOTREXATE SODIUM, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NUTRILIPID, OCTAGAM, ONDANSETRON HCL, ONDANSETRON HYDROCHLORIDE, ONDANSETRON ODT, OXALIPLATIN, PANZYGA, PARAPLATIN, PENTAMIDINE ISETHIONATE, PLENAMINE, PREHEVBRIO, PREMASOL, PRIVIGEN, PROGRAF, PROSOL, PULMOZYME, RABAVERT, RECOMBIVAX HB, SIROLIMUS, TACROLIMUS, TENIVAC, TOBRAMYCIN, TPN ELECTROLYTES, TRAVASOL, TREXALL, TROPHAMINE, VARUBI, XATMEP, YUPELRI, ZOLEDRONIC ACID
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	N/A
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Group	BAFIERTAM
Drug Names	BAFIERTAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BALVERSA
Drug Names	BALVERSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For urothelial carcinoma: 1) disease has susceptible fibroblast growth factor receptor 3 (FGFR3) or fibroblast growth factor receptor 2 (FGFR2) genetic alterations AND 2) the requested drug will be used as subsequent therapy for any of the following: a) locally advanced or metastatic urothelial carcinoma, b) recurrent primary carcinoma of the urethra, c) stage II-IV urothelial carcinoma of the bladder, d) urothelial carcinoma of the bladder with metastatic or local recurrence post cystectomy, or e) urothelial carcinoma of the bladder with muscle invasive local recurrence or persistent disease in a preserved bladder.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BANZEL
Drug Names	RUFINAMIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BENLYSTA
Drug Names	BENLYSTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	For patients new to therapy: severe active central nervous system lupus.
Required Medical Information	For systemic lupus erythematosus (SLE): 1) patient is currently receiving a stable standard therapy regimen (e.g., corticosteroid, antimalarial, or NSAIDs) for SLE, OR 2) patient has experienced an intolerance or has a contraindication to standard therapy regimen for SLE. For lupus nephritis: 1) patient is currently receiving a stable standard therapy regimen (e.g., corticosteroid, cyclophosphamide, mycophenolate mofetil, or azathioprine) for lupus nephritis OR 2) patient has experienced an intolerance or has a contraindication to standard therapy regimen for lupus nephritis.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BERINERT
Drug Names	BERINERT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acute angioedema attacks due to hereditary angioedema (HAE): Patient meets either of the following: 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	5 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BESREMI
Drug Names	BESREMI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BETASERON
Drug Names	BETASERON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BOSENTAN
Drug Names	BOSENTAN, TRACLEER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BOSULIF
Drug Names	BOSULIF
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Philadelphia chromosome positive B-cell acute lymphoblastic leukemia (Ph+ B-ALL), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I, G250E, V299L, and F317L, AND 3) patient has experienced resistance or intolerance to imatinib or dasatinib. For B-ALL including patient who have received hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, and 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I, G250E, V299L, and F317L.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BRAFTOVI
Drug Names	BRAFTOVI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Adjuvant systemic therapy for cutaneous melanoma, appendiceal adenocarcinoma
Exclusion Criteria	-
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): 1) Tumor is positive for BRAF V600E mutation, AND 2) The requested drug will be used for either of the following: a) subsequent therapy for advanced or metastatic disease, b) primary treatment for unresectable metachronous metastases. For melanoma: 1) Tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with binimetinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BRIVIACT
Drug Names	BRIVIACT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older).
Age Restrictions	1 month of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BRUKINSA
Drug Names	BRUKINSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	BYDUREON
Drug Names	BYDUREON BCISE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	10 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	The Prior Authorization only applies to patients whose claim is not submitted with an ICD-10 code indicating a diagnosis of type 2 diabetes mellitus OR to patients who do not have a history of an antidiabetic drug (EXCLUDING glucagon-like peptide receptor agonists [GLP-1 RAs] and combination glucose-dependent insulinotropic polypeptide [GIP] and GLP-1 RAs).

Prior Authorization Group	BYETTA
Drug Names	BYETTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	The Prior Authorization only applies to patients whose claim is not submitted with an ICD-10 code indicating a diagnosis of type 2 diabetes mellitus OR to patients who do not have a history of an antidiabetic drug (EXCLUDING glucagon-like peptide receptor agonists [GLP-1 RAs] and combination glucose-dependent insulinotropic polypeptide [GIP] and GLP-1 RAs).

Prior Authorization Group	BYLVAY
Drug Names	BYLVAY, BYLVAY (PELLETS)
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of pruritis in progressive familial intrahepatic cholestasis (PFIC) (initial requests): 1) diagnosis of PFIC has been confirmed by genetic testing, 2) the patient does not have PFIC type 2 with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3), 3) the patient does not have any other concomitant liver disease, AND 4) the patient has not received a liver transplant. For treatment of pruritis in PFIC (continuation requests): the patient has experienced benefit from therapy (for example, improvement in pruritis). For treatment of cholestatic pruritus with Alagille Syndrome (ALGS) (continuation): the patient has experienced benefit from therapy (for example, improvement in pruritis).
Age Restrictions	For PFIC: 3 months of age or older, For ALGS: 12 months of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist or gastroenterologist
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-

Prior Authorization Group	CABOMETYX
Drug Names	CABOMETYX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-small cell lung cancer, Ewing sarcoma, osteosarcoma, gastrointestinal stromal tumor, endometrial carcinoma
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma: The disease is advanced, relapsed, or stage IV. For non-small cell lung cancer: 1) the disease is rearranged during transfection (RET) positive AND 2) the disease is recurrent, advanced, or metastatic. For hepatocellular carcinoma: the requested drug will be used as subsequent treatment. For gastrointestinal stromal tumor (GIST): The patient meets either of the following: 1) the disease is unresectable, recurrent/progressive, or metastatic AND the patient has failed a FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib) OR 2) the requested drug will be used for palliation of symptoms if previously tolerated and effective. For Ewing sarcoma and osteosarcoma: the requested drug will be used as subsequent therapy. For differentiated thyroid cancer (DTC) (follicular, papillary, Hurthle cell): 1) The disease is locally advanced or metastatic disease, 2) the disease has progressed after a vascular endothelial growth factor receptor (VEGFR)- targeted therapy, AND 3) the patient is refractory to radioactive iodine therapy (RAI) or ineligible for RAI.For endometrial carcinoma: 1) the disease is recurrent or metastatic AND 2) the requested drug will be used as subsequent therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CALQUENCE
Drug Names	CALQUENCE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Waldenstrom macroglobulinemia (lymphoplasmacytic lymphoma), marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma)
Exclusion Criteria	-
Required Medical Information	For marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, and splenic marginal zone lymphoma): the requested drug is being used for the treatment of relapsed, refractory, or progressive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CAMZYOS
Drug Names	CAMZYOS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For obstructive hypertropic cardiomyopathy: 1) before initiating therapy, patient has left ventricular ejection fraction (LVEF) of 55 percent or greater AND 2) patient has New York Heart Association (NYHA) class II-III symptoms.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CAPRELSA
Drug Names	CAPRELSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CARBAGLU
Drug Names	CARGLUMIC ACID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For N-acetylglutamate synthase (NAGS) deficiency: Diagnosis of NAGS deficiency was confirmed by enzymatic, biochemical, or genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CAYSTON
Drug Names	CAYSTON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of respiratory symptoms in cystic fibrosis patients: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CERDELGA
Drug Names	CERDELGA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For type 1 Gaucher disease (GD1): 1) Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing, and 2) Patient's CYP2D6 metabolizer status has been established using an FDA-cleared test, and 3) Patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CEREZYME
Drug Names	CEREZYME
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Type 2 Gaucher disease, Type 3 Gaucher disease.
Exclusion Criteria	-
Required Medical Information	For Gaucher disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CHOLBAM
Drug Names	CHOLBAM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For bile acid synthesis disorders due to single enzyme defects (SEDs) and adjunctive treatment of peroxisomal disorders (PDs): Diagnosis was confirmed by mass spectrometry or other biochemical or genetic testing. For bile acid synthesis disorders due to SEDs and adjunctive treatment of PDs, continuation of therapy: Patient has achieved and maintained improvement in liver function.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-

Prior Authorization Group	CIBINQO
Drug Names	CIBINQO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For atopic dermatitis (AD), continuation of therapy: Patient achieved or maintained positive clinical response.
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Initial: 4 months, Continuation: Plan Year
Other Criteria	-

Prior Authorization Group	CINRYZE
Drug Names	CINRYZE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prevention of acute angioedema attacks due to hereditary angioedema (HAE): Patient meets either of the following: 1) the patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing and either of the following: a) Patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR b) Patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CLOBAZAM
Drug Names	CLOBAZAM
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Seizures associated with Dravet syndrome
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	Seizures associated with Lennox-Gastaut syndrome (LGS): 2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	COMETRIQ
Drug Names	COMETRIQ
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell.
Exclusion Criteria	-
Required Medical Information	For NSCLC: The requested medication is used for NSCLC when the patient's disease expresses rearranged during transfection (RET) gene rearrangements.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	COPIKTRA
Drug Names	COPIKTRA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Hepatosplenic T-Cell lymphoma, breast implant-associated anaplastic large cell lymphoma (ALCL), peripheral T-Cell lymphoma
Exclusion Criteria	-
Required Medical Information	For chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), breast implant-associated anaplastic large cell lymphoma (ALCL), and peripheral T-Cell lymphoma: the patient has relapsed or refractory disease. For hepatosplenic T-Cell lymphoma: the patient has refractory disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CORTROPHIN
Drug Names	CORTROPHIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the following diagnoses, patient has experienced an inadequate treatment response to a parenteral or an oral glucocorticoid (for ophthalmic diseases only, inadequate response to a trial of a topical ophthalmic glucocorticoid is also acceptable): 1) For rheumatic disorders (e.g., psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis, acute gouty arthritis): The requested drug must be used as adjunctive treatment, 2) For nephrotic syndrome: the requested drug must be requested for induction of diuresis or for remission of proteinuria, 3) For multiple sclerosis (MS): patient has an acute exacerbation of MS, 4) Collagen diseases (e.g., systemic lupus erythematosus, dermatomyositis, or polymyositis), 5) Dermatologic diseases (e.g., severe erythema multiforme, Stevens-Johnson syndrome, severe psoriasis), 6) Ophthalmic diseases, acute or chronic (e.g., iritis, keratitis, optic neuritis), 7) Symptomatic sarcoidosis, 8) Allergic states (e.g., serum sickness, atopic dermatitis).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	MS exacerbation: 3 wks. Allergic states: 1 month. All other diagnoses: 3 months
Other Criteria	-

Prior Authorization Group	COTELLIC
Drug Names	COTELLIC
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Central nervous system (CNS) cancer (i.e., glioma, glioblastoma, astrocytoma, oligodendroglioma), adjuvant systemic therapy for cutaneous melanoma.
Exclusion Criteria	-
Required Medical Information	For central nervous system (CNS) cancer (i.e., glioma, glioblastoma, astrocytoma, oligodendroglioma): 1) The tumor is positive for BRAF V600E activating mutation, AND 2) The requested drug will be used in combination with vemurafenib. For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used in combination with vemurafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CRINONE
Drug Names	CRINONE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Prophylaxis for premature birth in women with a short cervix
Exclusion Criteria	Prescribed to promote fertility
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CUVRIOR
Drug Names	CUVRIOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Documented diagnosis of Wilson's disease in patients with stable disease who are de-coppered and tolerant to penicillamine.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CYSTADROPS
Drug Names	CYSTADROPS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystinosis: 1) Diagnosis was confirmed by ANY of the following: a) the presence of increased cystine concentration in leukocytes, OR b) genetic testing, OR c) demonstration of corneal cystine crystals by slit lamp examination, AND 2) the patient has corneal cystine crystal accumulation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CYSTAGON
Drug Names	CYSTAGON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For nephropathic cystinosis: Diagnosis was confirmed by ANY of the following: 1) the presence of increased cystine concentration in leukocytes, OR 2) genetic testing, OR 3) demonstration of corneal cystine crystals by slit lamp examination.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	CYSTARAN
Drug Names	CYSTARAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystinosis: 1) Diagnosis was confirmed by ANY of the following: a) the presence of increased cystine concentration in leukocytes, OR b) genetic testing, OR c) demonstration of corneal cystine crystals by slit lamp examination, AND 2) the patient has corneal cystine crystal accumulation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DALFAMPRIDINE
Drug Names	DALFAMPRIDINE ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For multiple sclerosis, patient must meet the following: For new starts, prior to initiating therapy, patient demonstrates sustained walking impairment. For continuation of therapy: patient must have experienced an improvement in walking speed OR other objective measure of walking ability since starting the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DAURISMO
Drug Names	DAURISMO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Post induction therapy following response to previous therapy with the same regimen for acute myeloid leukemia (AML). Relapsed/refractory AML as a component of repeating the initial successful induction regimen.
Exclusion Criteria	-
Required Medical Information	For acute myeloid leukemia: 1) the requested drug must be used in combination with cytarabine, 2) the patient is 75 years of age or older OR has comorbidities that preclude intensive chemotherapy, AND 3) the requested drug will be used as treatment for induction therapy, post-induction therapy, or relapsed or refractory disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DAYBUE
Drug Names	DAYBUE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DEFERASIROX
Drug Names	DEFERASIROX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DIACOMIT
Drug Names	DIACOMIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	6 months of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DICLOFENAC EPOLAMINE PATCH
Drug Names	DICLOFENAC EPOLAMINE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Must have a documented diagnosis of acute pain due to one of the following: minor strain, sprain, or contusion.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	DOPTELET
Drug Names	DOPTELET
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For thrombocytopenia in patients with chronic liver disease: Untransfused platelet count prior to a scheduled procedure is less than 50,000/mcL. For chronic immune thrombocytopenia (ITP): 1) For new starts: a) Patient has had an inadequate response or is intolerant to prior therapy such as corticosteroids or immunoglobulins, AND b) Untransfused platelet count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000 to 50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease and hypertension, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma). 2) For continuation of therapy, platelet count response to the requested drug: a) Current platelet count is less than or equal to 200,000/mcL OR b) Current platelet count is greater than 200,000/mcL and less than or equal to 400,000/mcL and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Chronic liver disease: 1 month, ITP initial: 6 months, ITP reauthorization: Plan Year
Other Criteria	-

Prior Authorization Group	DUPIXENT
Drug Names	DUPIXENT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For atopic dermatitis (AD), initial therapy: 1) Patient has moderate-to-severe disease, AND 2) Patient has had an inadequate treatment response to either a topical corticosteroid or a topical calcineurin inhibitor, OR topical corticosteroids and topical calcineurin inhibitors are not advisable for the patient. For AD, continuation of therapy: Patient achieved or maintained positive clinical response. For oral corticosteroid dependent asthma, initial therapy: Patient has inadequate asthma control despite current treatment with both of the following medications: 1) High-dose inhaled corticosteroid AND 2) Additional controller (i.e., long acting beta2-agonist, long-acting, muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For moderate-to-severe asthma, initial therapy: Patient has a baseline blood eosinophil count of at least 150 cells per microliter and their asthma remains inadequately controlled despite current treatment with both of the following medications: 1) Medium-to-high-dose inhaled corticosteroid, AND 2) Additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For chronic rhinosinusitis with nasal polyposis (CRSwNP): 1) The requested drug is used as add-on maintenance treatment, AND 2) Patient has experienced an inadequate treatment response to Xhance (fluticasone).
Age Restrictions	Atopic Dermatitis: 6 months of age or older, Asthma: 6 years of age or older, Chronic Rhinosinusitis with Nasal Polyposis and Prurigo Nodularis: 18 years of age or older, Eosinophilic Esophagitis: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	AD, initial: 4 months, PN, initial: 6 months, All others: Plan Year
Other Criteria	For eosinophilic esophagitis (EoE), initial therapy: 1) Diagnosis has been confirmed by esophageal biopsy, AND 2) Patient weighs at least 40 kilograms, AND 3) Patient experienced an inadequate treatment response, intolerance, or patient has a contraindication to a topical corticosteroid (e.g., fluticasone propionate or budesonide). For EoE, continuation of therapy: Patient achieved or maintained a positive clinical response. For prurigo nodularis (PN), initial therapy: Patient has had an inadequate treatment response to a topical corticosteroid OR topical corticosteroids are not advisable for the patient. For PN, continuation of therapy: Patient achieved or maintained a positive clinical response.

Prior Authorization Group	EGRIFTA
Drug Names	EGRIFTA SV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Use for weight loss
Required Medical Information	For human immunodeficiency virus (HIV)-infected patients with lipodystrophy: Patient is receiving anti-retroviral therapy. For patients who have received at least 6 months of the requested drug: Patient has demonstrated clear clinical improvement from baseline that is supported by a waist circumference measurement or computed tomography (CT) scan.
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist or endocrinologist
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	ELIGARD
Drug Names	ELIGARD
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent androgen receptor positive salivary gland tumors
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EMFLAZA
Drug Names	EMFLAZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Must have a documented diagnosis of Duchenne muscular dystrophy (DMD).
Age Restrictions	-
Prescriber Restrictions	Must be prescribed by a neurologist or a provider who specializes in the treatment of DMD.
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ENBREL
Drug Names	ENBREL, ENBREL MINI, ENBREL SURECLICK
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Hidradenitis suppurativa, non-radiographic axial spondyloarthritis
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR the patient has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis AND 2) patient meets any of the following: a) the patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e. at least 10% of the BSA or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected). For hidradenitis suppurativa (new starts only): patient has severe, refractory disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ENSPRYNG
Drug Names	ENSPRYNG
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EPCLUSA
Drug Names	EPCLUSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance
Other Criteria	-

Prior Authorization Group	EPIDIOLEX
Drug Names	EPIDIOLEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EPRONTIA
Drug Names	EPRONTIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1)The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older). For monotherapy treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response or intolerance to topiramate tablets or capsules, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules). For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) If the patient is 6 years of age or older, the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam. For the preventative treatment of migraines: 1) The patient has experienced an inadequate treatment response or intolerance to topiramate tablets or capsules, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	Epilepsy: 2 years of age or older, Migraine: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ERGOTAMINE
Drug Names	ERGOTAMINE TARTRATE/CAFFE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin).
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least ONE triptan 5-HT1 agonist.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ERIVEDGE
Drug Names	ERIVEDGE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Adult medulloblastoma
Exclusion Criteria	-
Required Medical Information	For adult medulloblastoma: patient has received prior systemic therapy AND has tumor(s) with mutations in the sonic hedgehog pathway.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ERLEADA
Drug Names	ERLEADA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ERLOTINIB
Drug Names	ERLOTINIB HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer (NSCLC), recurrent chordoma, relapsed or stage IV renal cell carcinoma (RCC), brain metastases from non-small cell lung cancer (NSCLC), recurrent pancreatic cancer.
Exclusion Criteria	-
Required Medical Information	For NSCLC (including brain metastases from NSCLC): 1) the disease is recurrent, advanced, or metastatic and 2) the patient has sensitizing EGFR mutation-positive disease. For pancreatic cancer: the disease is locally advanced, unresectable, recurrent, or metastatic.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ESBRIET
Drug Names	PIRFENIDONE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For idiopathic pulmonary fibrosis (new starts only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EUCRISA
Drug Names	EUCRISA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For mild to moderate atopic dermatitis, the patient meets either of the following criteria: 1) If the patient is 2 years of age or older and the requested drug will be used on sensitive skin areas (e.g., face, genitals, or skin folds), the patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor OR 2) If the patient is 2 years of age or older and the requested drug is being prescribed for use on non-sensitive (or remaining) skin areas, the patient experienced an inadequate treatment response, intolerance, or contraindication to a medium or higher potency topical corticosteroid or a topical calcineurin inhibitor.
Age Restrictions	3 months of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EVENITY
Drug Names	EVENITY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Patients who have had a myocardial infarction or stroke within the preceding year.
Required Medical Information	For postmenopausal osteoporosis, patient has ONE of the following: 1) history of fragility fracture, OR 2) pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), or b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, or c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months lifetime total
Other Criteria	Patient has high Fracture Risk Assessment Tool (FRAX) fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day.

Prior Authorization Group	EVEROLIMUS
Drug Names	EVEROLIMUS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Classic Hodgkin lymphoma, thymomas and thymic carcinomas, previously treated Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma (perivascular epithelioid cell tumors (PEComa) and lymphangioleiomyomatosis subtypes), gastrointestinal stromal tumors, neuroendocrine tumors of the thymus, well differentiated grade 3 neuroendocrine tumors, thyroid carcinoma (papillary, Hurthle cell, and follicular), endometrial carcinoma, histiocytic neoplasms (Rosai-Dorfman Disease, Erdheim-Chester Disease, Langerhans Cell Histiocytosis)
Exclusion Criteria	-
Required Medical Information	For breast cancer: 1) The disease is recurrent unresectable, advanced, or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, AND 2) The requested drug is prescribed in combination with exemestane, fulvestrant, or tamoxifen, AND 3) The requested drug is used for subsequent treatment. For renal cell carcinoma: The disease is relapsed, advanced, or stage IV. For subependymal giant cell astrocytoma (SEGA): The requested drug is given as adjuvant treatment. For gastrointestinal stromal tumor: The disease is recurrent/progressive, unresectable, or metastatic AND the patient failed an FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib). For symptomatic or relapsed/refractory Erdheim-Chester Disease (ECD), symptomatic or relapsed/refractory Rosai-Dorfman Disease, and Langerhans Cell Histiocytosis (LCH): the patient must have a phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EVRYSDI
Drug Names	EVRYSDI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For spinal muscular atrophy (SMA) initial therapy, patient meets all of the following: 1) Patient has type 1, type 2, or type 3 SMA, and 2) Patient is not dependent on permanent ventilation. For SMA continuation of therapy, patient meets all of the following: 1) Patient has type 1, type 2, or type 3 SMA, AND 2) Patient has experienced clinically significant functional improvement or maintenance of muscle function.
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with a physician who specializes in spinal muscular atrophy
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	EXKIVITY
Drug Names	EXKIVITY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FABRAZYME
Drug Names	FABRAZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Fabry disease, the patient meets ANY of the following: 1) diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, OR 2) the patient is a symptomatic obligate carrier.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FASENRA
Drug Names	FASENRA, FASENRA PEN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Severe asthma, initial therapy: 1) Either a) Patient has baseline blood eosinophil count of at least 150 cells per microliter OR b) Patient is dependent on systemic corticosteroids, and 2) Patient has a history of severe asthma despite current treatment with both of the following medications: a) medium-to-high-dose inhaled corticosteroid and b) additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. Severe asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose.
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FENTANYL PATCH
Drug Names	FENTANYL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FILSPARI
Drug Names	FILSPARI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For reduction of proteinuria in patients with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression: 1) The patient had an inadequate response to therapy with a maximally tolerated dose of a renin-angiotensin system (RAS) inhibitor (e.g., angiotensin-converting enzyme [ACE] inhibitor or angiotensin-receptor blocker [ARB]) OR 2) The patient experienced an intolerance or has a contraindication to RAS inhibitors.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FINTEPLA
Drug Names	FINTEPLA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FIRMAGON
Drug Names	FIRMAGON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Must have a documented diagnosis of advanced Prostate cancer.
Age Restrictions	-
Prescriber Restrictions	Must be prescribed by an oncologist or a urologist specializing in prostate cancer.
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FOTIVDA
Drug Names	FOTIVDA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For advanced renal cell carcinoma: the following criteria must be met: 1) The disease is relapsed or refractory, 2) The requested drug must be used after at least two prior systemic therapies, and 3) The patient has experienced disease progression or an intolerable adverse event with a trial of Cabometyx (cabozantinib).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FRUZAQLA
Drug Names	FRUZAQLA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	FYCOMPA
Drug Names	FYCOMPA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri, Spritam. For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam.
Age Restrictions	Partial-onset seizures (i.e., focal-onset seizures): 4 years of age or older. Primary generalized tonic-clonic seizures: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GATTEX
Drug Names	GATTEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For short bowel syndrome (SBS) initial therapy: 1) If the request is for an adult patient, the patient has been dependent on parenteral support for at least 12 months OR 2) If the request is for a pediatric patient, the patient is dependent on parenteral support. For SBS continuation: Requirement for parenteral support has decreased from baseline while on therapy with the requested drug.
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, gastrointestinal surgeon, or nutritional support specialist.
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GAVRETO
Drug Names	GAVRETO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent rearranged during transfection (RET) rearrangement-positive non-small cell lung cancer
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced, or metastatic, and 2) The tumor is rearranged during transfection (RET) fusion-positive or RET rearrangement-positive.
Age Restrictions	Non-small cell lung cancer: 18 years of age or older. Medullary thyroid cancer and thyroid cancer: 12 years of age or older.
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GILENYA
Drug Names	FINGOLIMOD, GILENYA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GILOTRIF
Drug Names	GILOTRIF
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): Patient meets either of the following: 1) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, OR 2) Patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GLATIRAMER
Drug Names	GLATIRAMER ACETATE, GLATOPA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GOCOVRI
Drug Names	GOCOVRI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GRALISE
Drug Names	GRALISE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Postherpetic neuralgia: The patient has experienced an inadequate treatment response or intolerance to gabapentin immediate-release
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	GROWTH HORMONE
Drug Names	GENOTROPIN, GENOTROPIN MINIQUICK, HUMATROPE, NORDITROPIN FLEXPRO, NUTROPIN AQ NUSPIN 10, NUTROPIN AQ NUSPIN 20, NUTROPIN AQ NUSPIN 5, OMNITROPE, SOGROYA, ZOMACTON
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	Pediatric patients with closed epiphyses
Required Medical Information	Pediatric growth hormone deficiency (GHD): Patient (pt) is a neonate or was diagnosed with GHD as a neonate OR meets any of the following: 1) younger than 2.5 years old (yo) with pre-treatment (pre-tx) height (ht) more than 2 standard deviations (SD) below mean and slow growth velocity OR 2) 2.5 yo or older AND one of the following: a) pre-tx 1-year ht velocity more than 2 SD below mean OR b) pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean, AND patient meets any of the following: 1) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), OR 2) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean. Turner syndrome (TS): 1) Confirmed by karyotyping AND 2) pre-tx ht is less than the 5th percentile for age. Small for gestational age (SGA): 1) Birth weight (wt) less than 2500g at gestational age (GA) greater than 37 weeks, OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) did not manifest catch-up growth by age 2.
Age Restrictions	SGA: 2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, or geneticist.
Coverage Duration	Plan Year
Other Criteria	Adult GHD: Pt meets any of the following: 1) failed 2 pre-tx GH stimulation tests, OR 2) pre-tx IGF-1 more than 2 SD below mean AND failed 1 pre-tx GH stimulation test. (Note: Stimulation tests include: a) insulin tolerance test [ITT] [peak GH less than or equal to 5 ng/ml], or b) Macrilen-stimulation test [peak GH level less than 2.8ng/ml], or c) glucagon-stimulation test [GST] [peak GH level less than or equal to 3 ng/ml] for pt with a body mass index [BMI] 25-30 kg/m2 and high pretest probability of GHD [e.g., acquired structural abnormalities] or BMI less than 25 kg/m2, or d) GST [peak GH level less than or equal to 1 ng/ml] in pt with BMI 25-30 kg/m2 and low pretest probability of GHD or BMI greater than 30 kg/m2), OR 3) organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation) with 3 or more pituitary hormone deficiencies AND pre-tx IGF-1 more than 2 SD below mean, OR 4) genetic or structural hypothalamic-pituitary defects, OR 5) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS. Renewal for pediatric GHD, TS, SGA, and adult GHD: Patient is experiencing improvement.

Prior Authorization Group	HAEGARDA
Drug Names	HAEGARDA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prevention of acute angioedema attacks due to hereditary angioedema (HAE): The patient meets either of the following: 1) the patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing and either of the following: a) patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR b) patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	HARVONI
Drug Names	HARVONI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria applied consistent w/ current AASLD-IDSA guidance. Reminder for 8wk option if appropriate.
Other Criteria	-

Prior Authorization Group	HERCEPTIN
Drug Names	HERCEPTIN, HERCEPTIN HYLECTA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma.
Exclusion Criteria	-
Required Medical Information	All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	HERZUMA
Drug Names	HERZUMA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma.
Exclusion Criteria	-
Required Medical Information	All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	HETLIOZ
Drug Names	TASIMELTEON
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Non-24-Hour Sleep-Wake Disorder: 1) For initial therapy and continuation of therapy the patient must meet both of the following: a) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and b) unable to perceive light in either eye, AND 2) If currently on therapy with the requested drug, patient must meet at least one of the following: a) increased total nighttime sleep or b) decreased daytime nap duration. For nighttime sleep disturbances in Smith-Magenis Syndrome (SMS): 1) For initial therapy and continuation therapy, the patient has a confirmed diagnosis of SMS AND 2) If currently on therapy with the requested drug, the patient experienced improvement in the quality of sleep since starting therapy.
Age Restrictions	Non-24: 18 years of age or older. SMS: 16 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist, neurologist, or psychiatrist.
Coverage Duration	Initiation: 6 Months, Renewal: Plan Year
Other Criteria	-

Prior Authorization Group	HETLIOZ LQ
Drug Names	HETLIOZ LQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For nighttime sleep disturbances in Smith-Magenis Syndrome (SMS): 1) For initial therapy and continuation therapy, the patient has a confirmed diagnosis of SMS AND 2) If currently on therapy with the requested drug, the patient experienced improvement in the quality of sleep since starting therapy.
Age Restrictions	3 to 15 years of age
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist
Coverage Duration	Initiation: 6 Months, Renewal: Plan Year.
Other Criteria	-

Prior Authorization Group	HUMIRA
Drug Names	ADALIMUMAB-AACF (2 PEN), HADLIMA, HADLIMA PUSHTOUCH, HUMIRA, HUMIRA PEDIATRIC CROHNS D, HUMIRA PEN, HUMIRA PEN-CD/UC/HS START, HUMIRA PEN-PEDIATRIC UC S, HUMIRA PEN-PS/UV STARTER, IDACIO (2 PEN), IDACIO (2 SYRINGE), IDACIO STARTER PACKAGE FO
PA Indication Indicator	All Medically-accepted Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR the patient has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) the patient meets any of the following: a) the patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) the patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the BSA or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For non-infectious intermediate, posterior and panuveitis (new starts only): 1) patient has experienced an inadequate treatment response or intolerance to a corticosteroid OR 2) the patient has a contraindication that would prohibit a trial of corticosteroids.

Prior Authorization Group	IBRANCE
Drug Names	IBRANCE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Unresectable well-differentiated/dedifferentiated liposarcoma of the retroperitoneum, recurrent hormone receptor-positive human epidermal growth factor receptor 2 (HER2)-negative breast cancer
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ICATIBANT
Drug Names	ICATIBANT ACETATE, SAJAZIR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acute angioedema attacks due to hereditary angioedema (HAE): Patient meets either of the following: 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ICLUSIG
Drug Names	ICLUSIG
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myeloid and/or lymphoid neoplasms with eosinophilia and FGFR1 or ABL1 rearrangement in the chronic phase or blast phase
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant: 1) patient has accelerated or blast phase CML and no other kinase inhibitor is indicated OR 2) patient has chronic phase CML and has experienced resistance or intolerance to at least 2 prior kinase inhibitors AND at least one of those was imatinib or dasatinib OR 3) patient is positive for the T315I mutation. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	IDHIFA
Drug Names	IDHIFA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Newly-diagnosed acute myeloid leukemia
Exclusion Criteria	-
Required Medical Information	For acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation: 1) patient is 60 years of age or older with newly-diagnosed AML and meets one of the following: a) patient is not a candidate for intensive induction therapy, or b) patient declines intensive induction chemotherapy, OR 2) patient is 60 years of age or older and the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug, OR 3) patient has relapsed or refractory AML.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	IMATINIB
Drug Names	IMATINIB MESYLATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), recurrent chordoma, melanoma, Kaposi sarcoma, chronic graft versus host disease (cGVHD), T-cell acute lymphoblastic leukemia with ABL-class translocation, aggressive systemic mastocytosis for well-differentiated systemic mastocytosis (WDSM) or when eosinophilia is present with FIP1L1-PDGFRA fusion gene, myeloid and/or lymphoid neoplasms with eosinophilia and ABL1, FIP1L1-PDGFRA, or PDGFRB rearrangement in the chronic phase or blast phase
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant: diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For melanoma: c-Kit mutation is positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	IMBRUVICA
Drug Names	IMBRUVICA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Hairy cell leukemia, lymphoplasmacytic lymphoma, primary central nervous system (CNS) lymphoma, Human Immunodeficiency Virus (HIV) -related B-cell lymphoma, diffuse large B-cell lymphoma, post-transplant lymphoproliferative disorders, high-grade B-cell lymphoma, mantle cell lymphoma, marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma)
Exclusion Criteria	-
Required Medical Information	For mantle cell lymphoma: 1) the requested drug will be used as second-line or subsequent therapy, OR 2) the requested drug will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (rituximab, cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen, OR 3) the requested drug will be used as aggressive induction therapy. For marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, and splenic marginal zone lymphoma): the requested drug will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested drug will be used as a single agent for disease progression. For primary CNS lymphoma: 1) the disease is relapsed or refractory, OR 2) the requested drug is used for induction therapy as a single agent. For diffuse large B-cell lymphoma and high-grade B-cell lymphoma: the requested drug will be used as second-line or subsequent therapy. For HIV-related B-cell lymphoma: the requested drug will be used as a single agent and as second-line or subsequent therapy for relapsed disease. For post-transplant lymphoproliferative disorders: the requested drug will be used in patients who have received prior chemoimmunotherapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	INCRELEX
Drug Names	INCRELEX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Pediatric patients with closed epiphyses
Required Medical Information	For growth failure due to severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone (GH) gene deletion in patients who have developed neutralizing antibodies to GH, patient meets all of the following prior to beginning therapy with the requested drug (new starts only): 1) height 3 or more standard deviations (SD) below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more SD below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level. For growth failure due to severe primary IGF-1 deficiency or GH gene deletion in patients who have developed neutralizing antibodies to GH, continuation of therapy: patient is experiencing improvement.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	INGREZZA
Drug Names	INGREZZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Must have a documented diagnosis of tardive dyskinesia or chorea associated with Huntington's disease
Age Restrictions	-
Prescriber Restrictions	Must be prescribed by a neurologist or with consultation by a neurologist.
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	INLYTA
Drug Names	INLYTA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Thyroid carcinoma (papillary, Hurthle cell, or follicular), alveolar soft part sarcoma
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma: The disease is advanced, relapsed, or stage IV.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	INQOVI
Drug Names	INQOVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	INREBIC
Drug Names	INREBIC
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and janus kinase 2 (JAK2) rearrangement, accelerated phase myelofibrosis, blast phase myelofibrosis/acute myeloid leukemia
Exclusion Criteria	-
Required Medical Information	For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement: the disease is in chronic or blast phase.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	IR BEFORE ER
Drug Names	HYDROCODONE BITARTRATE ER, HYDROMORPHONE HCL ER, HYDROMORPHONE HYDROCHLORI, METHADONE HCL, MORPHINE SULFATE ER, OXYCODONE HYDROCHLORIDE E, OXYMORPHONE HYDROCHLORIDE, TRAMADOL HCL ER, TRAMADOL HYDROCHLORIDE ER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	IRESSA
Drug Names	GEFITINIB, IRESSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent non-small cell lung cancer (NSCLC).
Exclusion Criteria	-
Required Medical Information	For NSCLC: 1) disease must be metastatic, advanced, or recurrent and 2) patient must have a sensitizing EGFR mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ISTURISA
Drug Names	ISTURISA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	IVERMECTIN TAB
Drug Names	IVERMECTIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Ascariasis, Cutaneous larva migrans, Mansonelliasis, Scabies, Gnathostomiasis, Pediculosis
Exclusion Criteria	-
Required Medical Information	The requested drug is not being prescribed for the prevention or treatment of coronavirus disease 2019 (COVID-19).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-

Prior Authorization Group	JAKAFI
Drug Names	JAKAFI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Lower-risk myelofibrosis, accelerated phase myelofibrosis, blast phase myelofibrosis/acute myeloid leukemia, acute lymphoblastic leukemia (ALL), chronic myelomonocytic leukemia (CMML)-2, myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) with neutrophilia, essential thrombocythemia, and myeloid, lymphoid or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement
Exclusion Criteria	-
Required Medical Information	For polycythemia vera: patient had an inadequate response or intolerance to interferon therapy or hydroxyurea. For acute lymphoblastic leukemia: patient has a cytokine receptor-like factor 2 (CRLF2) mutation or a mutation associated with activation of the Janus kinase/signal transducers and activators of transcription (JAK/STAT) pathway. For CMML-2: the requested drug is used in combination with a hypomethylating agent. For myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) with neutrophilia: the requested drug is used as a single agent or in combination with a hypomethylating agent. For essential thrombocythemia: patient had an inadequate response or loss of response to hydroxyurea, interferon therapy, or anagrelide. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement: the disease is in chronic or blast phase.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	JUXTAPID
Drug Names	JUXTAPID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For initiation of therapy to treat homozygous familial hypercholesterolemia (HoFH), patient (pt) must meet ALL of the following: A) Diagnosis of HoFH confirmed by one of the following: 1) Genetic testing to confirm two mutant alleles at low-density lipoprotein receptor (LDLR), apolipoprotein B (ApoB), proprotein convertase subtilisin/kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1) gene locus OR 2) History of an untreated low-density lipoprotein-cholesterol (LDL-C) of greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL and either of the following: a) Presence of cutaneous or tendinous xanthomas before the age of 10 years, or b) An untreated LDL-C level of greater than or equal to 190 mg/dL in both parents, which is consistent with heterozygous familial hypercholesterolemia (HeFH), AND B) Prior to initiation of treatment, the pt is currently receiving treatment with a high-intensity statin at a maximally tolerated dose or at the maximum dose approved by the Food and Drug Administration (FDA) unless the pt is statin intolerant or has a contraindication to statin therapy, AND C) Prior to initiation of treatment with the requested drug, the pt is currently receiving treatment with a PCSK9-directed therapy at a maximally tolerated dose or at the maximum dose approved by the FDA unless the patient has experienced an intolerance or has a contraindication to all PCSK9-directed therapies, AND D) Prior to initiation of treatment, pt is/was experiencing an inadequate response to lipid-lowering therapy as indicated by a treated LDL-C greater than 100 mg/dL (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease), AND E) The pt will continue to receive concomitant lipid lowering therapy. For renewal of therapy to treat HoFH: A) Pt meets all initial criteria, AND B) Has responded to therapy as demonstrated by a reduction in LDL-C from baseline, AND C) Is receiving concomitant lipid lowering therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	KALYDECO
Drug Names	KALYDECO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis (CF): The requested medication will not be used in combination with other medications containing ivacaftor.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	KANJINTI
Drug Names	KANJINTI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma.
Exclusion Criteria	-
Required Medical Information	All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	KESIMPTA
Drug Names	KESIMPTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	KEVEYIS
Drug Names	KEVEYIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For primary HYPOkalemic periodic paralysis: 1) The diagnosis was supported by genetic test results, OR 2) Patient has a family history of primary hypokalemic periodic paralysis, OR 3) Patient's attacks are associated with hypokalemia AND both Andersen-Tawil syndrome and thyrotoxic periodic paralysis have been ruled out. For primary HYPERkalemic periodic paralysis: 1) The diagnosis was supported by genetic test results, OR 2) Patient has a family history of primary hyperkalemic periodic paralysis, OR 3) Patient's attacks are associated with hyperkalemia AND Andersen-Tawil syndrome has been ruled out. For continuation of therapy for primary HYPOkalemic and primary HYPERkalemic periodic paralysis: Patient is demonstrating a response to therapy with the requested drug as demonstrated by a decrease in the number or severity of attacks.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 2 months. Continuation: 12 months
Other Criteria	-

Prior Authorization Group	KEVZARA
Drug Names	KEVZARA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient has had an inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) patient has had an inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For polymyalgia rheumatica (PMR) (new starts only): 1) The patient has experienced an inadequate treatment response to corticosteroids OR 2) The patient has experienced a disease flare while attempting to taper corticosteroids.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	KINERET
Drug Names	KINERET
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Systemic juvenile idiopathic arthritis, adult-onset Still's disease, multicentric Castleman's disease, Schnitzler syndrome, and Erdheim-Chester disease.
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: Enbrel (etanercept), Humira (adalimumab), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib-extended release). For active systemic juvenile idiopathic arthritis (new starts only): patient must meet any of the following criteria: 1) Inadequate response to at least one nonsteroidal anti-inflammatory drug (NSAID), corticosteroid, methotrexate or leflunomide, 2) Inadequate response or intolerance to a prior biologic DMARD, OR 3) Physician global assessment score greater than or equal to 5.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	KISQALI
Drug Names	KISQALI, KISQALI FEMARA 200 DOSE, KISQALI FEMARA 400 DOSE, KISQALI FEMARA 600 DOSE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer, in combination with an aromatase inhibitor, or fulvestrant.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	KLISYRI
Drug Names	KLISYRI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following: A) imiquimod 5 percent cream, B) fluorouracil cream or solution.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	KORLYM
Drug Names	KORLYM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	KOSELUGO
Drug Names	KOSELUGO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	BRAF fusion or BRAF V600E activating mutation-positive recurrent or progressive pilocytic astrocytoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	For neurofibromatosis type 1: 2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	KRAZATI
Drug Names	KRAZATI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LAPATINIB
Drug Names	LAPATINIB DITOSYLATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Brain metastases from human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, recurrent epidermal growth factor receptor (EGFR)-positive chordoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma).
Exclusion Criteria	-
Required Medical Information	For breast cancer, the patient meets all the following: a) the disease is recurrent, advanced, or metastatic (including brain metastases), b) the disease is human epidermal growth factor receptor 2 (HER2)-positive, c) the requested drug will be used in combination with any of the following: 1) aromatase inhibitor, 2) capecitabine, OR 3) trastuzumab. For colorectal cancer: 1) requested drug will be used in combination with trastuzumab and 2) patient has not had previous treatment with a HER2 inhibitor.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LENVIMA
Drug Names	LENVIMA 10 MG DAILY DOSE, LENVIMA 12MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 18 MG DAILY DOSE, LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE, LENVIMA 4 MG DAILY DOSE, LENVIMA 8 MG DAILY DOSE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Medullary thyroid carcinoma, recurrent endometrial carcinoma, thymic carcinoma
Exclusion Criteria	-
Required Medical Information	For differentiated thyroid cancer (follicular, papillary, or Hurthle cell): disease is not amenable to radioactive iodine therapy and unresectable, locally recurrent, persistent, or metastatic. For hepatocellular carcinoma: disease is unresectable or inoperable, local, metastatic or with extensive liver tumor burden. For renal cell carcinoma, the disease is advanced, relapsed, or stage IV. For endometrial carcinoma, the patient meets ALL of the following: 1) The disease is advanced, recurrent, or metastatic, 2) The requested drug will be used in combination with pembrolizumab, 3) The patient experienced disease progression following prior systemic therapy, AND 4) The patient is not a candidate for curative surgery or radiation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LEUPROLIDE
Drug Names	LEUPROLIDE ACETATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Use in combination with growth hormone for children with growth failure and advancing puberty, recurrent androgen receptor positive salivary gland tumors, central precocious puberty.
Exclusion Criteria	-
Required Medical Information	For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, AND 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, AND 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients.
Age Restrictions	CPP: Patient must be less than 12 years old if female and less than 13 years old if male
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LIDOCAINE PATCHES
Drug Names	LIDOCAINE, LIDOCAN III
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]).
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LIQREV
Drug Names	LIQREV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LIVMARLI
Drug Names	LIVMARLI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For treatment of cholestatic pruritis in a patient with Alagille syndrome (ALGS) (continuation): the patient has experienced benefit from therapy (for example, improvement in pruritis).
Age Restrictions	3 months of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	-

Prior Authorization Group	LIVTENCITY
Drug Names	LIVTENCITY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist, transplant specialist, hematologist, or oncologist.
Coverage Duration	3 months
Other Criteria	-

Prior Authorization Group	LONSURF
Drug Names	LONSURF
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): The disease is advanced or metastatic. For gastric or gastroesophageal junction adenocarcinoma, all of the following criteria must be met: 1) The disease is unresectable locally advanced, recurrent, or metastatic, and 2) The patient has been previously treated with at least two prior lines of chemotherapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LORBRENA
Drug Names	LORBRENA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Anaplastic lymphoma kinase (ALK)-positive recurrent non-small cell lung cancer (NSCLC). Repressor of silencing (ROS)-1 rearrangement-positive recurrent, advanced, or metastatic NSCLC following progression on crizotinib, entrectinib, or ceritinib. Symptomatic or relapsed/refractory ALK-positive Erdheim-Chester Disease. Inflammatory myofibroblastic tumor (IMT) with ALK translocation.
Exclusion Criteria	-
Required Medical Information	For recurrent, advanced, or metastatic NSCLC: Patient has ALK-positive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LUMAKRAS
Drug Names	LUMAKRAS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent KRAS G12C-positive non-small cell lung cancer (NSCLC)
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LUMIZYME
Drug Names	LUMIZYME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Pompe disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LUPKYNIS
Drug Names	LUPKYNIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Use in combination with cyclophosphamide
Required Medical Information	For lupus nephritis: 1) patient is currently receiving background immunosuppressive therapy (e.g., mycophenolate mofetil, corticosteroids) for lupus nephritis, OR 2) patient has an intolerance or has a contraindication to background immunosuppressive therapy regimen for lupus nephritis. For lupus nephritis continuation: patient is receiving benefit from therapy and the benefit of continuing therapy outweighs the risk of worsening nephrotoxicity.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LUPRON-PROSTATE CA
Drug Names	LUPRON DEPOT (1-MONTH), LUPRON DEPOT (3-MONTH), LUPRON DEPOT (4-MONTH), LUPRON DEPOT (6-MONTH)
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Malignant sex cord-stromal tumors
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	LYNPARZA
Drug Names	LYNPARZA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent HER2-negative, BRCA 1/2-germline mutated breast cancer, recurrent or metastatic HER2-positive, BRCA 1/2-germline mutated breast cancer, uterine leiomyosarcoma.
Exclusion Criteria	-
Required Medical Information	For recurrent or metastatic breast cancer: the disease is BRCA 1/2-germline mutated. For prostate cancer: 1) The patient has a BRCA mutation and the requested drug will be used in combination with abiraterone and either prednisone or prednisolone OR 2) The patient has progressed on prior treatment with an androgen receptor-directed therapy. For epithelial ovarian, fallopian tube, or primary peritoneal cancer: The requested drug is used for maintenance therapy for stage II-IV or recurrent disease who are in complete or partial response to chemotherapy. For uterine leiomyosarcoma: 1) the patient has had at least one prior therapy AND 2) the patient has BRCA-altered disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	MAVYRET
Drug Names	MAVYRET
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh [CTP] class B or C).
Required Medical Information	For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance
Other Criteria	-

Prior Authorization Group	MEKINIST
Drug Names	MEKINIST
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Langerhans cell histiocytosis, Erdheim-Chester disease, Rosai-Dorfman disease.
Exclusion Criteria	-
Required Medical Information	For melanoma: 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with dabrafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy. For central nervous system (CNS) cancer (i.e., glioma, oligodendroglioma, astrocytoma, glioblastoma), non-small cell lung cancer, solid tumors, and anaplastic thyroid cancer: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used in combination with dabrafenib. For uveal melanoma: The requested drug will be used as a single agent. For ovarian cancer, fallopian tube cancer, and primary peritoneal cancer: The requested drug will be used to treat persistent or recurrent disease. For gallbladder cancer, intrahepatic cholangiocarcinoma, and extrahepatic cholangiocarcinoma: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The disease is unresectable or metastatic, AND 3) The requested drug will be used in combination with dabrafenib. For papillary, follicular, and hurthle cell thyroid carcinoma: 1) The disease is positive for BRAF V600E mutation, AND 2) The disease is not amenable to radioactive iodine (RAI) therapy, AND 3) The requested drug will be used in combination with dabrafenib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	MEKTOVI
Drug Names	MEKTOVI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Adjuvant systemic therapy for cutaneous melanoma, Langerhans Cell Histiocytosis
Exclusion Criteria	-
Required Medical Information	For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used in combination with encorafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	MIGLUSTAT
Drug Names	MIGLUSTAT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For type 1 Gaucher disease (GD1): Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	MISCELLANEOUS INJECTABLES
Drug Names	ABELCET, ACYCLOVIR SODIUM, AMPHOTERICIN B, AMPHOTERICIN B LIPOSOME
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Diagnosis of an FDA-approved indication not otherwise excluded from Part D.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	MODAFINIL
Drug Names	MODAFINIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For excessive sleepiness associated with narcolepsy: The diagnosis has been confirmed by sleep lab evaluation. For excessive sleepiness associated with obstructive sleep apnea (OSA): The diagnosis has been confirmed by polysomnography.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	MOVANTIK
Drug Names	MOVANTIK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Must have documented diagnosis of opioid-induced constipation caused by opioids taken for chronic non-cancer pain, including patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	MULPLETA
Drug Names	MULPLETA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For thrombocytopenia in patients with chronic liver disease: Untransfused platelet count prior to a scheduled procedure is less than 50,000/mcL.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-

Prior Authorization Group	MVASI
Drug Names	MVASI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Ampullary adenocarcinoma, breast cancer, central nervous system (CNS) cancers, malignant pleural mesothelioma, malignant peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity.
Exclusion Criteria	-
Required Medical Information	For all indications except ophthalmic-related disorders: The patient had an intolerable adverse event to Zirabev and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	MYCAPSSA
Drug Names	MYCAPSSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	MYFEMBREE
Drug Names	MYFEMBREE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For heavy menstrual bleeding associated with uterine leiomyomas (fibroids) and moderate to severe pain associated with endometriosis in a premenopausal patient: the patient has not already received greater than or equal to 24 months of treatment with the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months, max 24 months total
Other Criteria	-

Prior Authorization Group	MYTESI
Drug Names	MYTESI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Must have a documented diagnosis of non-infective diarrhea related to receiving anti-retroviral therapy for HIV. Must rule out any infectious types of diarrhea before initiation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NATPARA
Drug Names	NATPARA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Acute postsurgical hypoparathyroidism (within 6 months of surgery) and expected recovery from hypoparathyroidism.
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NERLYNX
Drug Names	NERLYNX
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, brain metastases from HER2-positive breast cancer.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NEXAVAR
Drug Names	NEXAVAR, SORAFENIB TOSYLATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Acute myeloid leukemia, soft tissue sarcoma (angiosarcoma, desmoid tumors/aggressive fibromatosis, and solitary fibrous tumor subtypes), gastrointestinal stromal tumor, medullary thyroid carcinoma, osteosarcoma, recurrent chordoma, epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer, lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia
Exclusion Criteria	-
Required Medical Information	For acute myeloid leukemia: the disease is FMS-like tyrosine kinase 3-internal tandem duplication (FLT3-ITD) mutation-positive AND either of the following is met (1 OR 2): 1) the requested drug will be used as maintenance therapy after hematopoietic stem cell transplant, OR 2) the requested drug is used in combination with azacitidine or decitabine for low-intensity treatment induction or post-induction therapy AND either a) the patient has is 60 years of age or older or b) the disease is relapsed/refractory. For thyroid carcinoma: histology is follicular, papillary, Hurthle cell or medullary. For gastrointestinal stromal tumor (GIST): the patient meets either of the following: 1) the disease is unresectable, recurrent/progressive, or metastatic AND the patient has failed on an FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib) OR 2) the requested drug is being used for palliation of symptoms if previously tolerated and effective. For renal cell carcinoma: the disease is advanced. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia: 1) the disease has a FLT3 rearrangement AND 2) the disease is in chronic or blast phase.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NEXLETOL
Drug Names	NEXLETOL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NEXLIZET
Drug Names	NEXLIZET
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NGENLA
Drug Names	NGENLA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Pediatric patients with closed epiphyses
Required Medical Information	For pediatric growth hormone deficiency (GHD), initial: A) Patient (pt) has pre-treatment (pre-tx) 1-year height (ht) velocity more than 2 standard deviations (SD) below mean OR a pre-tx ht more than 2 SD below mean and a 1-year ht velocity more than 1 SD below mean AND pt meets any of the following: 1) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), 2) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean OR B) Pt was diagnosed with GHD as a neonate. For pediatric GHD, continuation of therapy: Pt is experiencing improvement.
Age Restrictions	3 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NINLARO
Drug Names	NINLARO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Relapsed/refractory systemic light chain amyloidosis, Waldenstrom macroglobulinemia, lymphoplasmacytic lymphoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NITISINONE
Drug Names	NITISINONE, ORFADIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hereditary tyrosinemia type 1 (HT-1): Diagnosis of HT-1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) OR 2) DNA testing (mutation analysis).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NORTHERA
Drug Names	DROXIDOPA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For neurogenic orthostatic hypotension (nOH): Prior to initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing or head-up tilt test. For continuation of therapy for nOH, patient must experience a sustained reduction in symptoms of nOH (i.e., decrease in dizziness, lightheadedness, or feeling faint). For both initial and continuation of therapy for nOH, the requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) dopamine beta-hydroxylase deficiency, OR 3) non-diabetic autonomic neuropathy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 months
Other Criteria	-

Prior Authorization Group	NOXAFIL SUSP
Drug Names	POSACONAZOLE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will be used orally. For treatment of oropharyngeal candidiasis: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to fluconazole.
Age Restrictions	13 years of age or older
Prescriber Restrictions	-
Coverage Duration	Oropharyngeal candidiasis: 1 month. All other indications: 6 months
Other Criteria	-

Prior Authorization Group	NUBEQA
Drug Names	NUBEQA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NUCALA
Drug Names	NUCALA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For severe asthma, initial therapy: 1) Either a) Patient has baseline blood eosinophil count of at least 150 cells per microliter OR b) Patient is dependent on systemic corticosteroids, and 2) Patient has a history of severe asthma despite current treatment with both of the following medications: a) medium-to-high-dose inhaled corticosteroid and b) additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For severe asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For eosinophilic granulomatosis with polyangiitis (EGPA), initial therapy: Patient has a history or the presence of an eosinophil count of more than 1000 cells per microliter or a blood eosinophil level of greater than 10 percent. For EGPA, continuation of therapy: Patient has a beneficial response to treatment with the requested drug, as demonstrated by any of the following: 1) a reduction in the frequency of relapses, 2) a reduction in the daily oral corticosteroid dose, or 3) no active vasculitis. For hypereosinophilic syndrome (HES), initial therapy: 1) Patient has had HES for greater than or equal to 6 months, 2) Patient has HES without an identifiable non-hematologic secondary cause, 3) Patient does not have FIP1L1-PDGFRA kinase-positive HES, 4) Patient has a history or presence of a blood eosinophil count of at least 1000 cells per microliter, AND 5) Patient has been on a stable dose of at least one HES therapy (e.g., oral corticosteroid, immunosuppressive, and/or cytotoxic therapy). For HES, continuation of therapy: Patient has a beneficial response to treatment as demonstrated by a reduction in HES flares.
Age Restrictions	Asthma: 6 years of age or older, EGPA and CRSwNP: 18 years of age or older, HES: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For chronic rhinosinusitis with nasal polyps (CRSwNP): 1) The requested drug is used as add-on maintenance treatment, AND 2) The patient has experienced inadequate treatment response to Xhance (fluticasone).

Prior Authorization Group	NUEDEXTA
Drug Names	NUEDEXTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NUPLAZID
Drug Names	NUPLAZID
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hallucinations and delusions associated with Parkinson's disease psychosis, the diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	NURTEC
Drug Names	NURTEC
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Acute migraine treatment: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to one triptan 5-HT1 receptor agonist . Preventive treatment of migraine, initial: The patient meets either of the following: 1) The patient experienced an inadequate treatment response with a 4-week trial of any one of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants OR 2) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any one of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants. Preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Preventive treatment of migraine - initial: 3 months, All other indications: Plan Year
Other Criteria	-

Prior Authorization Group	OCALIVA
Drug Names	OCALIVA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For primary biliary cholangitis (PBC) without cirrhosis or with compensated cirrhosis without evidence of portal hypertension: For initial therapy, 1) Diagnosis of PBC (previously known as primary biliary cirrhosis) is confirmed by at least two of the following: A) Biochemical evidence of cholestasis with elevation of alkaline phosphatase (ALP) level for at least 6 months duration, B) Presence of antimitochondrial antibodies (AMA) (titer greater than 1:40 by immunofluorescence or immunoenzymatic reactivity) or PBC-specific antinuclear antibodies ANA (eg, anti-gp210, anti-sp100), or C) Histologic evidence of PBC on liver biopsy (eg, non-suppurative inflammation and destruction of interlobular and septal bile ducts) and 2) Patient has an elevated serum ALP level prior to initiation of therapy with the requested drug and meets one of the following requirements: A) Inadequate response to at least 12 months of prior therapy with ursodeoxycholic acid (UDCA)/ursodiol and the patient will continue concomitant therapy with UDCA/ursodiol, or B) Intolerance to UDCA/ursodiol. For continuation of therapy for PBC: patient achieved or maintained a clinical benefit from Ocaliva therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 6 months. Continuation: Plan Year.
Other Criteria	-

Prior Authorization Group	OCTREOTIDE
Drug Names	OCTREOTIDE ACETATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Tumor control of thymomas and thymic carcinomas.
Exclusion Criteria	-
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy. For tumor control of thymomas and thymic carcinomas: The requested drug will be used for any of the following: 1) locally advanced or metastatic disease, 2) postoperatively following tumor resection.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ODOMZO
Drug Names	ODOMZO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	OFEV
Drug Names	OFEV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For idiopathic pulmonary fibrosis (new starts only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	OGIVRI
Drug Names	OGIVRI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma.
Exclusion Criteria	-
Required Medical Information	All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	OGSIVEO
Drug Names	OGSIVEO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	OJJAARA
Drug Names	OJJAARA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	OMNIPOD
Drug Names	OMNIPOD 5 G6 INTRO KIT (G, OMNIPOD 5 G6 PODS (GEN 5), OMNIPOD CLASSIC PODS (GEN, OMNIPOD DASH INTRO KIT (G, OMNIPOD DASH PDM KIT (GEN, OMNIPOD DASH PODS (GEN 4), OMNIPOD POD PALS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Omnipod GO, initial: 1) the patient has diabetes requiring insulin management AND 2) the patient is currently self-testing glucose levels, the patient will be counseled on self-testing glucose levels, or the patient is using a continuous glucose monitor AND 3) the patient has experienced an inadequate treatment response or intolerance to long-acting basal insulin therapy. Omnipod, V-GO, initial: 1) The patient has diabetes requiring insulin management with multiple daily injections AND 2) The patient is self-testing glucose levels 4 or more times per day OR the patient is using a continuous glucose monitor AND 3) The patient has experienced any of the following with the current diabetes regimen: inadequate glycemic control, recurrent hypoglycemia, wide fluctuations in blood glucose, dawn phenomenon with persistent severe early morning hyperglycemia, severe glycemic excursions.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ONUREG
Drug Names	ONUREG
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	OPSUMIT
Drug Names	OPSUMIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ORAL-INTRANASAL FENTANYL
Drug Names	FENTANYL CITRATE, FENTANYL CITRATE ORAL TRA, LAZANDA, SUBSYS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	1) The requested drug is indicated for the treatment of breakthrough cancer-related pain only. The requested drug is being prescribed for the management of breakthrough pain in a cancer patient with underlying cancer pain AND 2) The International Classification of Diseases (ICD) diagnosis code provided supports the cancer-related diagnosis. [Note: For drug coverage approval, ICD diagnosis code provided MUST support the cancer-related diagnosis.] AND 3) The patient is currently receiving, and will continue to receive, around-the-clock opioid therapy for underlying cancer pain AND 4) The requested drug is intended only for use in opioid tolerant patients. The patient can safely take the requested dose based on their current opioid use history. [Note: Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 60 mg of oral hydrocodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg of oral oxymorphone per day, or an equianalgesic dose of another opioid medication daily for one week or longer.].
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ORALAIR
Drug Names	ORALAIR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Severe, unstable or uncontrolled asthma. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. History of eosinophilic esophagitis.
Required Medical Information	-
Age Restrictions	5 to 65 years of age
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ORENITRAM
Drug Names	ORENITRAM, ORENITRAM TITRATION KIT M
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ORGOVYX
Drug Names	ORGOVYX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ORIAHNN
Drug Names	ORIAHNN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in a premenopausal patient: the patient has not already received greater than or equal to 24 months of treatment with any elagolix-containing drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 months, max 24 months total
Other Criteria	-

Prior Authorization Group	ORKAMBI
Drug Names	ORKAMBI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis (CF): The requested medication will not be used in combination with other medications containing ivacaftor.
Age Restrictions	1 year of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ORLADEYO
Drug Names	ORLADEYO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prevention of acute angioedema attacks due to hereditary angioedema (HAE): The patient meets either of the following: 1) the patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing and either of the following: a) patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR b) patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	OTEZLA
Drug Names	OTEZLA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For plaque psoriasis (new starts only): Patient meets either of the following: 1) Inadequate treatment response or intolerance to ANY of the following: a) a topical therapy (e.g., topical corticosteroids, calcineurin inhibitors, vitamin D analogs), b) phototherapy (e.g., UVB, PUVA), or c) pharmacologic treatment with methotrexate, cyclosporine, or acitretin, OR 2) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	OXANDROLONE
Drug Names	OXANDROLONE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Cachexia associated with AIDS (HIV wasting). To enhance growth in patients with Turners Syndrome
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Turners Syndrome: Plan Year, All other diagnoses: 6 months
Other Criteria	Coverage will be denied if request is for an indication excluded from Medicare Part D.

Prior Authorization Group	OXERVATE
Drug Names	OXERVATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	8 weeks
Other Criteria	-

Prior Authorization Group	OZEMPIC
Drug Names	OZEMPIC
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	The Prior Authorization only applies to patients whose claim is not submitted with an ICD-10 code indicating a diagnosis of type 2 diabetes mellitus OR to patients who do not have a history of an antidiabetic drug (EXCLUDING glucagon-like peptide receptor agonists [GLP-1 RAs] and combination glucose-dependent insulinotropic polypeptide [GIP] and GLP-1 RAs).

Prior Authorization Group	PALYNZIQ
Drug Names	PALYNZIQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	PANRETIN
Drug Names	PANRETIN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Topical treatment of cutaneous lesions in patients with non-AIDS-related Kaposi sarcoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	PAROXETINE SUSP
Drug Names	PAROXETINE HYDROCHLORIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Patient is unable to take solid oral dosage forms (e.g., difficulty swallowing tablets or capsules).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	PEGASYS
Drug Names	PEGASYS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, symptomatic lower-risk myelofibrosis), systemic mastocytosis, adult T-cell leukemia/lymphoma, mycosis fungoides/sezary syndrome, primary cutaneous CD30+ T-cell lymphoproliferative disorders, hairy cell leukemia, Erdheim-Chester disease, initial treatment during pregnancy for chronic myeloid leukemia.
Exclusion Criteria	-
Required Medical Information	For chronic hepatitis C: Hepatitis C virus (HCV) confirmed by presence of hepatitis C virus HCV RNA in serum prior to starting treatment and the planned treatment regimen.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	HCV: 12-48wks. Criteria applied consistent w/current AASLD/IDSA guidance. HBV: 48wks. Other: Plan Yr
Other Criteria	-

Prior Authorization Group	PEMAZYRE
Drug Names	PEMAZYRE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	PHENYLBUTYRATE
Drug Names	OLPRUVA, SODIUM PHENYLBUTYRATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For urea cycle disorders (UCD): Diagnosis of UCD was confirmed by enzymatic, biochemical, or genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	PIQRAY
Drug Names	PIQRAY 200MG DAILY DOSE, PIQRAY 250MG DAILY DOSE, PIQRAY 300MG DAILY DOSE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated breast cancer in combination with fulvestrant.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	POMALYST
Drug Names	POMALYST
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Relapsed/refractory systemic light chain amyloidosis, primary central nervous system (CNS) lymphoma, POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome.
Exclusion Criteria	-
Required Medical Information	For multiple myeloma, patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent AND a proteasome inhibitor.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	PREVYMIS
Drug Names	PREVYMIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For prophylaxis of cytomegalovirus (CMV) infection or disease in hematopoietic stem cell transplant (HSCT): 1) the patient is CMV-seropositive, AND 2) the patient is a recipient of an allogeneic HSCT. For prophylaxis of CMV disease in kidney transplant: 1) the patient is CMV-seronegative, AND 2) the patient is a high risk recipient of kidney transplant.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	7 months
Other Criteria	-

Prior Authorization Group	PROCRIT
Drug Names	PROCRIT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Anemia due to myelodysplastic syndromes (MDS), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa)
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	Requirements regarding hemoglobin (Hgb) values exclude values due to a recent transfusion. For initial approval: 1) for all uses except anemia due to chemotherapy or myelodysplastic syndrome (MDS): patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%), AND 2) for all uses except surgery: pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, AND 3) for MDS: pretreatment serum erythropoietin level is 500 international units/L or less. For reauthorizations (patient received erythropoietin treatment in previous month) in all uses except surgery: 1) patient has received at least 12 weeks of erythropoietin therapy, AND 2) patient responded to erythropoietin therapy, AND 3) current Hgb is less than 12 g/dL, AND 4) for all uses except anemia due to chemotherapy or MDS: patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	16 weeks
Other Criteria	Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).

Prior Authorization Group	PROLIA
Drug Names	PROLIA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For postmenopausal osteoporosis, patient (pt) has ONE of the following: 1) history of fragility fracture, OR 2) pre-treatment (pre-tx) T-score of less than or equal to -2.5 or pre-tx T-score greater than -2.5 and less than -1 with a high pre-tx Fracture Risk Assessment Tool (FRAX) fracture probability AND pt has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), b) pt has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, or c) pt has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For osteoporosis in men: pt has one of the following: 1) history of osteoporotic vertebral or hip fracture, OR 2) pre-tx T-score of less than or equal to -2.5 or pre-tx T-score greater than -2.5 and less than -1 with a high pre-tx FRAX fracture probability AND patient has ANY of the following: a) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, OR b) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For glucocorticoid-induced osteoporosis: 1) pt has had an oral bisphosphonate trial of at least 1-year duration unless pt has a contraindication or intolerance to an oral bisphosphonate, AND 2) pt has one of the following: a) history of fragility fracture, OR b) pre-tx T-score of less than or equal to -2.5, OR c) pre-tx T-score greater than -2.5 and less than -1 with a high pre-tx FRAX fracture probability. For breast cancer, pt is receiving adjuvant aromatase inhibitor therapy. For prostate cancer, pt is receiving androgen deprivation therapy (ADT).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.

Prior Authorization Group	PROMACTA
Drug Names	PROMACTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) Patient (pt) has had an inadequate response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins AND b) Untransfused platelet (plt) count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease and hypertension, anticoagulation therapy, profession or lifestyle that predisposes pt to trauma) AND c) For chronic ITP only: pt has had an inadequate response or intolerance to Doptelet (avatrombopag). 2) For continuation of therapy, plt count response to the requested drug: a) Current plt count is less than or equal to 200,000/mcL, OR b) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: 1) For new starts: the requested drug is used for initiation and maintenance of interferon-based therapy. 2) For continuation of therapy: pt is receiving interferon-based therapy. For severe aplastic anemia (AA): 1) For new starts: a) Pt will use the requested drug with standard immunosuppressive therapy for first line treatment OR b) the pt had an insufficient response to immunosuppressive therapy. 2) For continuation of therapy: 1) Current plt count is 50,000-200,000/mcL, OR 2) Current plt count is less than 50,000/mcL and pt has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and pt is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks
Other Criteria	APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL).

Prior Authorization Group	PYRUKYND
Drug Names	PYRUKYND, PYRUKYND TAPER PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hemolytic anemia in a patient with pyruvate kinase (PK) deficiency: Diagnosis was confirmed by an enzyme assay demonstrating deficiency of PK enzyme activity or by genetic testing. For hemolytic anemia in a patient with PK deficiency (continuation of therapy): Patient achieved or maintained a positive clinical response (e.g., improvement in hemoglobin levels, reduction in blood transfusions).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 7 months, Continuation: Plan Year
Other Criteria	-

Prior Authorization Group	QINLOCK
Drug Names	QINLOCK
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent/progressive or unresectable gastrointestinal stromal tumor (GIST)
Exclusion Criteria	-
Required Medical Information	For unresectable, recurrent/progressive, advanced, or metastatic gastrointestinal stromal tumor (GIST), the patient meets either of the following: 1) patient has received prior treatment with 3 or more kinase inhibitors, including imatinib OR 2) patient has experienced disease progression following treatment with avapritinib and dasatinib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	QUININE SULFATE
Drug Names	QUININE SULFATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Babesiosis, uncomplicated Plasmodium vivax malaria.
Exclusion Criteria	-
Required Medical Information	For babesiosis: the requested drug is used in combination with clindamycin.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-

Prior Authorization Group	RADICAVA
Drug Names	RADICAVA, RADICAVA ORS STARTER KIT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For amyotrophic lateral sclerosis (ALS): 1) Diagnosis is classified as definite or probable ALS, AND 2) For new starts only: Patient has scores of at least 2 points on all 12 areas of the revised ALS Functional Rating Scale (ALSFRS-R). For continuation of therapy for ALS: There is a clinical benefit from therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RAVICTI
Drug Names	RAVICTI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For urea cycle disorders (UCD): Diagnosis of UCD was confirmed by enzymatic, biochemical or genetic testing.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RECORLEV
Drug Names	RECORLEV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RELISTOR INJ
Drug Names	RELISTOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of opioid-induced constipation in a patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation: 1) the patient is unable to tolerate oral medications OR 2) the patient meets one of the following criteria A) experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in a patient with chronic non-cancer pain (e.g., Movantik) OR B) the patient has a contraindication that would prohibit a trial of an oral drug indicated for opioid-induced constipation in a patient with chronic non-cancer pain (e.g., Movantik).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	4 months
Other Criteria	-

Prior Authorization Group	RELISTOR TAB
Drug Names	RELISTOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	4 months
Other Criteria	-

Prior Authorization Group	REMICADE
Drug Names	INFLIXIMAB, REMICADE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Behcet's syndrome, hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis.
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) Pt meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) or leflunomide OR b) intolerance or CI to MTX AND leflunomide, AND 2) Pt meets ANY of the following: a) inadequate response, intolerance or CI to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Pt meets ANY of the following: a) pt has experienced inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with MTX, cyclosporine, or acitretin, OR b) pharmacologic treatment with MTX, cyclosporine, or acitretin is contraindicated, OR c) pt has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of BSA or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For hidradenitis suppurativa (new starts only): Pt has severe, refractory disease. For uveitis (new starts only): Inadequate response or intolerance or has a CI to a trial of immunosuppressive therapy for uveitis. For FDA-approved indications and off-label uses that overlap: The patient had an intolerable adverse event to Renflexis and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.

Prior Authorization Group	RENFLEXIS
Drug Names	RENFLEXIS
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Behcet's syndrome, hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) Pt meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) or leflunomide OR b) intolerance or CI to MTX AND leflunomide, AND 2) pt meets ANY of the following: a) inadequate response, intolerance or CI to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Pt meets ANY of the following: a) pt has experienced inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with MTX, cyclosporine, or acitretin, OR b) pharmacologic treatment with MTX, cyclosporine, or acitretin is contraindicated, OR c) pt has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of BSA or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For hidradenitis suppurativa (new starts only): pt has severe, refractory disease. For uveitis (new starts only): Inadequate response or intolerance or has a CI to a trial of immunosuppressive therapy for uveitis.

Prior Authorization Group	REPATHA
Drug Names	REPATHA, REPATHA PUSHTRONEX SYSTEM, REPATHA SURECLICK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RETACRIT
Drug Names	RETACRIT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Anemia due to myelodysplastic syndromes (MDS), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa)
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	Requirements regarding hemoglobin (Hgb) values exclude values due to a recent transfusion. For initial approval: 1) for all uses except anemia due to chemotherapy or myelodysplastic syndrome (MDS): patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%), AND 2) for all uses except surgery: pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, AND 3) for MDS: pretreatment serum erythropoietin level is 500 international units/L or less. For reauthorizations (patient received erythropoietin treatment in previous month) in all uses except surgery: 1) patient has received at least 12 weeks of erythropoietin therapy, AND 2) patient responded to erythropoietin therapy, AND 3) current Hgb is less than 12 g/dL, AND 4) for all uses except anemia due to chemotherapy or MDS: patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	16 weeks
Other Criteria	Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).

Prior Authorization Group	RETEVMO
Drug Names	RETEVMO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent rearranged during transfection (RET)-rearrangement positive non-small cell lung cancer, Langerhans Cell Histiocytosis with a RET gene fusion, symptomatic or relapsed/refractory Erdheim-Chester Disease with a RET gene fusion, symptomatic or relapsed/refractory Rosai-Dorfman Disease with a RET gene fusion, RET-fusion positive recurrent or persistent thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), RET-fusion positive anaplastic thyroid carcinoma.
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced or metastatic, and 2) Tumor is RET fusion-positive or RET rearrangement-positive.
Age Restrictions	Medullary thyroid cancer and thyroid cancer: 12 years of age or older.
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	REVLIMID
Drug Names	LENALIDOMIDE, REVLIMID
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Systemic light chain amyloidosis, classical Hodgkin lymphoma, myelodysplastic syndrome without the 5q deletion cytogenetic abnormality, myelofibrosis-associated anemia, POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome, myeloproliferative neoplasms, Kaposi Sarcoma, Langerhans cell histiocytosis, peripheral T-Cell lymphomas not otherwise specified, angioimmunoblastic T-cell lymphoma (AITL), enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma, adult T-cell leukemia/lymphoma, hepatosplenic T-cell lymphoma, primary central nervous system (CNS) lymphoma, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma, monomorphic post-transplant lymphoproliferative disorder, diffuse large B-cell lymphoma, multicentric Castleman's disease, high-grade B-cell lymphomas, histologic transformation of indolent lymphoma to diffuse large B-cell lymphoma.
Exclusion Criteria	-
Required Medical Information	For myelodysplastic syndrome (MDS): patient has lower risk MDS with symptomatic anemia per the Revised International Prognostic Scoring System (IPSS-R), International Prognostic Scoring System (IPSS), or World Health organization (WHO) classification-based Prognostic Scoring System (WPSS).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	REZUROCK
Drug Names	REZUROCK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RINVOQ
Drug Names	RINVOQ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]). For active psoriatic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one TNF inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]). For moderately to severely active ulcerative colitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., Humira [adalimumab]). For moderately to severely active Crohn's disease (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., Humira [adalimumab]). For atopic dermatitis (new starts only): 1) patient has refractory, moderate to severe disease, AND 2) patient has had an inadequate response to treatment with other systemic drug products, including biologics, or use of these therapies are inadvisable. For atopic dermatitis (continuation of therapy): the patient achieved or maintained positive clinical response. For active ankylosing spondylitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]). For non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor.
Age Restrictions	Atopic dermatitis: 12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Atopic dermatitis (initial): 4 months, All others: Plan Year
Other Criteria	-

Prior Authorization Group	ROZLYTREK
Drug Names	ROZLYTREK
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent ROS1-positive non-small cell lung cancer (NSCLC), Non-metastatic neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors.
Exclusion Criteria	-
Required Medical Information	For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, the disease is without a known acquired resistance mutation. For ROS1-positive non-small cell lung cancer, the patient has recurrent, advanced, or metastatic disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RUBRACA
Drug Names	RUBRACA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Uterine leiomyosarcoma, pancreatic adenocarcinoma, advanced (stage II-IV) epithelial ovarian, fallopian tube, or primary peritoneal cancer
Exclusion Criteria	-
Required Medical Information	For metastatic castration-resistant prostate cancer with a deleterious breast cancer susceptibility gene (BRCA) mutation (germline and/or somatic): 1) patient has been treated with androgen receptor-directed therapy, AND 2) patient has been treated with a taxane-based chemotherapy or the patient is not fit for chemotherapy, AND 3) the requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. For maintenance treatment of BRCA mutated epithelial ovarian, fallopian tube, primary peritoneal cancer: 1) the patient has advanced (stage II-IV) disease and is in complete or partial response to primary therapy, OR 2) the patient has recurrent disease and is in complete or partial response to platinum-based chemotherapy. For uterine leiomyosarcoma: 1) the requested drug is used as second-line therapy, AND 2) the patient has BRCA-altered disease. For pancreatic adenocarcinoma: 1) the patient has metastatic disease, AND 2) the patient has somatic or germline BRCA or PALB-2 mutations.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RYBELSUS
Drug Names	RYBELSUS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	The Prior Authorization only applies to patients whose claim is not submitted with an ICD-10 code indicating a diagnosis of type 2 diabetes mellitus OR to patients who do not have a history of an antidiabetic drug (EXCLUDING glucagon-like peptide receptor agonists [GLP-1 RAs] and combination glucose-dependent insulinotropic polypeptide [GIP] and GLP-1 RAs).

Prior Authorization Group	RYDAPT
Drug Names	RYDAPT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Relapsed or refractory acute myeloid leukemia (AML), myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 or FLT3 rearrangements, post-induction therapy for AML, re-induction in residual disease for AML
Exclusion Criteria	-
Required Medical Information	For acute myeloid leukemia (AML): AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and Fibroblast growth factor receptor type 1 (FGFR1) or FLT3 rearrangements: the disease is in chronic or blast phase.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SAPROPTERIN
Drug Names	JAVYGTOR, SAPROPTERIN DIHYDROCHLORI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For phenylketonuria (PKU): For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment (including before dietary management) phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced improvement (e.g., reduction in blood phenylalanine levels, improvement in neuropsychiatric symptoms).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 2 months, All others: Plan Year
Other Criteria	-

Prior Authorization Group	SAVELLA
Drug Names	SAVELLA, SAVELLA TITRATION PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to duloxetine or pregabalin.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SCEMBLIX
Drug Names	SCEMBLIX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML) in the chronic phase: 1) the diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene AND 2) the patient meets either of the following: A) the patient has previously been treated with 2 or more tyrosine kinase inhibitors (TKIs) AND at least one of those was imatinib or dasatinib, OR B) the patient is positive for the T315I mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SEROSTIM
Drug Names	SEROSTIM
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of human immunodeficiency virus (HIV) patients with wasting or cachexia: The requested medication is used in combination with antiretroviral therapy. Patient has had a suboptimal response to at least one other therapy for wasting or cachexia (e.g., megestrol, dronabinol, cyproheptadine, or testosterone therapy if hypogonadal) or patient has a contraindication or intolerance to alternative therapies. For continuation of therapy, patient must have demonstrated a response to therapy with the requested medication (i.e., body mass index [BMI] has increased or stabilized).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	12 weeks
Other Criteria	-

Prior Authorization Group	SIGNIFOR
Drug Names	SIGNIFOR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SILDENAFIL
Drug Names	SILDENAFIL CITRATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) If the request is for an adult, pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SIRTURO
Drug Names	SIRTURO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SKYCLARYS
Drug Names	SKYCLARYS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For Friedreich's ataxia (FRDA): 1) The patient has a confirmed genetic mutation in the frataxin (FXN) gene, AND 2) The patient is exhibiting clinical manifestations of the disease (e.g., muscle weakness, decline in coordination, frequent falling). For FRDA continuation of therapy: The patient has experienced a beneficial response to therapy (e.g., slowing of clinical decline).
Age Restrictions	16 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a physician who specializes in Friedreich's ataxia or a neurologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SKYRIZI
Drug Names	SKYRIZI, SKYRIZI PEN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient meets any of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected). For moderately to severely active Crohn's disease (new starts only): 1) patient has experienced an inadequate treatment response to at least one conventional therapy (e.g. corticosteroids), OR 2) patient has experienced an intolerance or has a contraindication to conventional therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SOHONOS
Drug Names	SOHONOS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For reduction in volume of new heterotopic ossification in fibrodysplasia ossificans progressiva (FOP): The patient has a confirmed genetic mutation in the activin A receptor type I (ACVR1) gene.
Age Restrictions	8 years of age or older if female and 10 years of age or older if male
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SOMAVERT
Drug Names	SOMAVERT
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SPRYCEL
Drug Names	SPRYCEL
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gastrointestinal stromal tumor (GIST), metastatic chondrosarcoma, recurrent chordoma, T-cell acute lymphoblastic leukemia (ALL), and Philadelphia (Ph)-like B-ALL, myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia (Ph) chromosome or BCR-ABL gene, and 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L. For acute lymphoblastic leukemia (ALL), the patient has a diagnosis of one of the following: 1) Philadelphia chromosome positive ALL, including patients who have received a hematopoietic stem cell transplant: diagnosis that has been confirmed by detection of the Ph chromosome or BCR-ABL gene, and if patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L, OR 2) Ph-like B-ALL with ABL-class kinase fusion, OR 3) relapsed or refractory T-cell ALL with ABL-class kinase fusion. For GIST, 1) the patient meets all of the following: A) the disease is unresectable, recurrent/progressive, or metastatic, B) the patient has received prior therapy with imatinib or avapritinib AND C) patients is positive for PDGFRA exon 18 mutations, OR 2) the requested drug is being used for palliation of symptoms.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	STELARA
Drug Names	STELARA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts): At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	STIVARGA
Drug Names	STIVARGA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Progressive gastrointestinal stromal tumors (GIST), osteosarcoma, glioblastoma, angiosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma, rhabdomyosarcoma, soft tissue sarcomas of the extremities, body wall, head and neck.
Exclusion Criteria	-
Required Medical Information	For gastrointestinal stromal tumors: The disease is progressive, locally advanced, unresectable, or metastatic. For colorectal cancer: The disease is advanced or metastatic.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SUNOSI
Drug Names	SUNOSI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For excessive daytime sleepiness associated with narcolepsy, initial request: 1) The diagnosis has been confirmed by sleep lab evaluation, AND 2) The patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil, modafinil). For excessive daytime sleepiness associated with obstructive sleep apnea (OSA), initial request: 1) The diagnosis has been confirmed by polysomnography, AND 2) The patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil, modafinil). If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in daytime sleepiness with obstructive sleep apnea (OSA).
Age Restrictions	-
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SUTENT
Drug Names	SUNITINIB MALATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Thyroid carcinoma (follicular, medullary, papillary, and Hurthle cell), soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, and alveolar soft part sarcoma subtypes), recurrent chordoma, thymic carcinoma, lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia, pheochromocytoma, paraganglioma, gastrointestinal stromal tumor (GIST) (unresectable, recurrent/progressive, or metastatic disease after progression on approved therapies, unresectable succinate dehydrogenase (SDH)-deficient GISTs and use for palliation of symptoms if previously tolerated and effective).
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma (RCC): the patient meets either of the following: 1) the disease is relapsed, advanced, or stage IV OR 2) the requested drug is being used as adjuvant treatment for patients that are at high risk of recurrent RCC following nephrectomy. For gastrointestinal stromal tumor (GIST): the patient meets one of the following: 1) the requested drug will be used after disease progression on or intolerance to imatinib, 2) the disease is unresectable, recurrent/progressive, or metastatic AND the patient has failed on an FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib), 3) the requested drug will be used for unresectable succinate dehydrogenase (SDH)-deficient GIST, OR 4) the requested drug will be used for the palliation of symptoms if previously tolerated and effective. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia: 1) the disease has a FLT3 rearrangement AND 2) the disease is in chronic or blast phase.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SYMDEKO
Drug Names	SYMDEKO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis: The requested medication will not be used in combination with other medications containing ivacaftor.
Age Restrictions	6 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SYMPAZAN
Drug Names	SYMPAZAN
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Seizures associated with Dravet syndrome
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	Seizures associated with Lennox-Gastaut syndrome (LGS): 2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TABRECTA
Drug Names	TABRECTA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer (NSCLC).
Exclusion Criteria	-
Required Medical Information	For recurrent, advanced, or metastatic NSCLC: Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TADALAFIL (BPH)
Drug Names	TADALAFIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Must have a documented diagnosis of Benign prostatic hyperplasia.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TADALAFIL (PAH)
Drug Names	ALYQ, TADALAFIL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TAFINLAR
Drug Names	TAFINLAR
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), central nervous system (CNS) cancer (i.e., oligodendroglioma, astrocytoma, glioblastoma), gallbladder cancer, extrahepatic cholangiocarcinoma, intrahepatic cholangiocarcinoma, Langerhans cell histiocytosis, Erdheim-Chester disease, ovarian cancer, fallopian tube cancer, and primary peritoneal cancer.
Exclusion Criteria	-
Required Medical Information	For central nervous system (CNS) cancer (i.e., glioma, oligodendroglioma, astrocytoma, glioblastoma): 1) The tumor is positive for a BRAF V600E mutation AND 2) The requested drug will be used in combination with trametinib. For melanoma: 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with trametinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy. For non-small cell lung cancer: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used as a single agent or in combination with trametinib. For papillary, follicular, and Hurthle cell thyroid carcinoma: 1) The tumor is BRAF-positive, AND 2) The disease is not amenable to radioactive iodine (RAI) therapy. For Langerhans Cell Histiocytosis and Erdheim-Chester Disease: The disease is positive for a BRAF V600E mutation. For gallbladder cancer, extrahepatic cholangiocarcinoma, and intrahepatic cholangiocarcinoma: 1) The disease is positive for a BRAF V600E mutation, AND 2) The disease is unresectable or metastatic, AND 3) The requested drug will be used in combination with trametinib. For solid tumors: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used in combination with trametinib. For ovarian cancer, fallopian tube cancer, and primary peritoneal cancer: 1) The disease is positive for BRAF V600E mutation, AND 2) The disease is persistent or recurrent, AND 3) The requested drug will be used in combination with trametinib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TAGRISSO
Drug Names	TAGRISSO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent non-small cell lung cancer (NSCLC), brain metastases from sensitizing EGFR mutation-positive NSCLC, leptomeningeal metastases from EGFR mutation-positive NSCLC.
Exclusion Criteria	-
Required Medical Information	For NSCLC, the requested drug is used in any of the following settings: 1) The patient meets both of the following: a) patient has metastatic, advanced, or recurrent NSCLC (including brain and/or leptomeningeal metastases from NSCLC) and b) patient has a sensitizing EGFR mutation OR 2) The patient meets both of the following: a) request is for adjuvant treatment of NSCLC following tumor resection and b) patient has EGFR mutation-positive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TAKHZYRO
Drug Names	TAKHZYRO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prevention of acute angioedema attacks due to hereditary angioedema (HAE): The patient meets either of the following: 1) the patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing and either of the following: a) patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR b) patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TALTZ
Drug Names	TALTZ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Otezla (apremilast), Skyrizi (risankizumab-rzaa) Stelara (ustekinumab). For active ankylosing spondylitis (new starts only): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active psoriatic arthritis (PsA) (new starts only): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Otezla (apremilast), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active non-radiographic axial spondyloarthritis (new starts only): patient meets any of the following: 1) patient has experienced an inadequate treatment response to a non-steroidal anti-inflammatory drug (NSAID) OR 2) patient has experienced an intolerance or has a contraindication to NSAIDs.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TALZENNA
Drug Names	TALZENNA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent germline breast cancer susceptibility gene (BRCA)-mutated breast cancer
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TARGRETIN TOPICAL
Drug Names	BEXAROTENE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Stage 2 or higher mycosis fungoides (MF)/Sezary syndrome (SS), chronic or smoldering adult T-cell leukemia/lymphoma (ATLL), primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TASIGNA
Drug Names	TASIGNA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase, pigmented villonodular synovitis/tenosynovial giant cell tumor
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant, 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, 2) patient has experienced resistance or intolerance to imatinib or dasatinib, AND 3) If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I, Y253H, E255K/V, and F359V/C/I mutations. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) if the patient has experienced resistance to an alternative tyrosine kinase inhibitor for ALL, patient is negative for T315I, Y253H, E255K/V, F359V/C/I and G250E. For gastrointestinal stromal tumor (GIST), the patients meets either of the following: 1) the disease is unresectable, recurrent/progressive, or metastatic AND the disease has progressed on at least 2 approved therapies (e.g. imatinib, sunitinib, dasatinib, regorafenib, ripretinib) OR 2) the requested drug is being prescribed for palliation of symptoms.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TAVNEOS
Drug Names	TAVNEOS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For continuation of treatment for severe anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis: the patient has experienced benefit from therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TAZAROTENE
Drug Names	TAZAROTENE, TAZORAC
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For plaque psoriasis, the patient meets the following criteria: 1) the patient has less than or equal to 20 percent of affected body surface area (BSA), AND 2) the patient experienced an inadequate treatment response or intolerance to at least one topical corticosteroid OR has a contraindication that would prohibit a trial of topical corticosteroids.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TAZVERIK
Drug Names	TAZVERIK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	Epithelioid sarcoma: 16 years of age or older, Follicular lymphoma: 18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TECFIDERA
Drug Names	DIMETHYL FUMARATE, DIMETHYL FUMARATE STARTER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TEGSEDI
Drug Names	TEGSEDI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For polyneuropathy of hereditary transthyretin-mediated amyloidosis initial therapy, patient is positive for a mutation of the TTR gene and exhibits clinical manifestation of disease. For polyneuropathy of hereditary transthyretin-mediated amyloidosis continuation, patient demonstrates a beneficial response to therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TEPMETKO
Drug Names	TEPMETKO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer (NSCLC).
Exclusion Criteria	-
Required Medical Information	For recurrent, advanced, or metastatic NSCLC: Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TERIPARATIDE
Drug Names	TERIPARATIDE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following: 1) history of fragility fracture, OR 2) pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has ONE of the following: 1) history of osteoporotic vertebral or hip fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability AND patient has ANY of the following: a) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, OR b) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Initial: 24 months, Continuation: Plan Year
Other Criteria	For glucocorticoid-induced osteoporosis: Patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND patient meets ANY of the following: 1) patient has a history of fragility fracture, OR 2) a pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability. Continuation of therapy: If the patient has received greater than or equal to 24 months of therapy with any parathyroid hormone analog: 1) The patient remains at or has returned to having a high risk for fracture, AND 2) The benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

Prior Authorization Group	TESTOSTERONE CYPIONATE INJ
Drug Names	DEPO-TESTOSTERONE, TESTOSTERONE CYPIONATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender Dysphoria
Exclusion Criteria	-
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TESTOSTERONE ENANTHATE INJ
Drug Names	TESTOSTERONE ENANTHATE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender Dysphoria
Exclusion Criteria	-
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TETRABENAZINE
Drug Names	TETRABENAZINE
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Tic disorders, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
Exclusion Criteria	-
Required Medical Information	For treatment of tardive dyskinesia and treatment of chorea associated with Huntington's disease: The patient has experienced an inadequate treatment response or intolerable adverse event to deutetrabenazine.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	THALOMID
Drug Names	THALOMID
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myelofibrosis-associated anemia, AIDS-related aphthous stomatitis, Kaposi sarcoma, chronic graft-versus-host disease, Crohn's disease, multicentric Castleman's disease, Rosai-Dorfman disease, Langerhans cell histiocytosis
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TIBSOVO
Drug Names	TIBSOVO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Conventional (grades 1-3) or dedifferentiated chondrosarcoma. Newly-diagnosed acute myeloid leukemia (AML) if 60-74 years of age and without comorbidities.
Exclusion Criteria	-
Required Medical Information	Patient has disease with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. For acute myeloid leukemia (AML): 1) patient has newly-diagnosed AML and meets one of the following: a) 75 years of age or older, b) patient has comorbidities that preclude use of intensive induction chemotherapy, or c) patient is 60 years of age or older and declines intensive induction chemotherapy, OR 2) patient is 60 years of age or older and the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug, OR 3) patient has relapsed or refractory AML. For locally advanced, unresectable, or metastatic cholangiocarcinoma: the requested drug will be used as subsequent treatment for progression on or after systemic treatment.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TOPICAL TESTOSTERONES
Drug Names	TESTOSTERONE, TESTOSTERONE PUMP
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender Dysphoria
Exclusion Criteria	-
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TOPICAL TRETINOIN
Drug Names	AVITA, TRETINOIN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TRAZIMERA
Drug Names	TRAZIMERA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma.
Exclusion Criteria	-
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor. For hepatobiliary carcinoma: 1) the disease is HER2 positive and 2) the requested drug is used in combination with pertuzumab.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	TRELSTAR
Drug Names	TRELSTAR MIXJECT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Gender dysphoria, ovarian suppression in breast cancer
Exclusion Criteria	-
Required Medical Information	For gender dysphoria, patient meets either of the following (1 or 2): 1) the requested drug is used to suppress puberty and the patient is at Tanner stage 2 or greater, OR 2) patient is undergoing gender transition, and the patient will receive the requested drug concomitantly with gender-affirming hormones. For breast cancer: 1) requested drug is being used for ovarian suppression in premenopausal patients and 2) the requested drug will be used in combination with endocrine therapy and 3) the disease is hormone receptor positive and 4) the disease is at a higher risk of recurrence (e.g., young age, high-grade tumor, lymph-node involvement).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TRIKAFTA
Drug Names	TRIKAFTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cystic fibrosis: The requested medication will not be used in combination with other medications containing ivacaftor.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TRULICITY
Drug Names	TRULICITY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	The Prior Authorization only applies to patients whose claim is not submitted with an ICD-10 code indicating a diagnosis of type 2 diabetes mellitus OR to patients who do not have a history of an antidiabetic drug (EXCLUDING glucagon-like peptide receptor agonists [GLP-1 RAs] and combination glucose-dependent insulinotropic polypeptide [GIP] and GLP-1 RAs).

Prior Authorization Group	TRUQAP
Drug Names	TRUQAP
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TRUXIMA
Drug Names	TRUXIMA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, extranodal marginal zone lymphoma), Burkitt lymphoma, primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma, histological transformation from indolent lymphomas to diffuse large B-cell lymphoma, histological transformation chronic lymphocytic leukemia (CLL)/SLL to diffuse large B-cell lymphoma, Castleman's disease, human immunodeficiency virus (HIV)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), B-cell lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, immune checkpoint inhibitor-related toxicities, pemphigus vulgaris, pediatric aggressive mature B-cell lymphomas, Rosai-Dorfman disease, and pediatric mature B-cell acute leukemia.
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis, AND2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	-

Prior Authorization Group	TUKYSA
Drug Names	TUKYSA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer
Exclusion Criteria	-
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): 1) the patient has advanced, unresectable, or metastatic disease AND 2) the patient has human epidermal growth factor receptor 2 (HER2)-positive disease AND 3) the patient has RAS wild-type disease AND 4) the requested drug will be used in combination with trastuzumab and 5) the patient has not previously been treated with a HER2 inhibitor.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TURALIO
Drug Names	TURALIO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Langerhans cell histiocytosis, Erdheim-Chester disease, Rosai-Dorfman disease
Exclusion Criteria	-
Required Medical Information	For Langerhans cell histiocytosis: 1) disease has colony stimulating factor 1 receptor (CSF1R) mutation. For Erdheim-Chester disease and Rosai-Dorfman disease: 1) disease has CSF1R mutation AND patient has any of the following: a) symptomatic disease OR b) relapsed/refractory disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	UBRELVY
Drug Names	UBRELVY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For acute treatment of migraine: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least one triptan 5-HT1 receptor agonist.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	UPTRAVI
Drug Names	UPTRAVI, UPTRAVI TITRATION PACK
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	V-GO
Drug Names	V-GO 20, V-GO 30, V-GO 40
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Omnipod GO, initial: 1) the patient has diabetes requiring insulin management AND 2) the patient is currently self-testing glucose levels, the patient will be counseled on self-testing glucose levels, or the patient is using a continuous glucose monitor AND 3) the patient has experienced an inadequate treatment response or intolerance to long-acting basal insulin therapy. Omnipod, V-GO, initial: 1) The patient has diabetes requiring insulin management with multiple daily injections AND 2) The patient is self-testing glucose levels 4 or more times per day OR the patient is using a continuous glucose monitor AND 3) The patient has experienced any of the following with the current diabetes regimen: inadequate glycemic control, recurrent hypoglycemia, wide fluctuations in blood glucose, dawn phenomenon with persistent severe early morning hyperglycemia, severe glycemic excursions.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VALCHLOR
Drug Names	VALCHLOR
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Chronic or smoldering adult T-cell leukemia/lymphoma (ATLL), Stage 2 or higher mycosis fungoides (MF)/Sezary syndrome (SS), primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, CD30-positive lymphomatoid papulosis (LyP), unifocal Langerhans cell histiocytosis (LCH) with isolated skin disease
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VALTOCO
Drug Names	VALTOCO 10 MG DOSE, VALTOCO 15 MG DOSE, VALTOCO 20 MG DOSE, VALTOCO 5 MG DOSE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Must have a documented diagnosis of a seizure disorder requiring acute treatment.
Age Restrictions	-
Prescriber Restrictions	Must be prescribed by a neurologist or must be prescribed after consultation with a neurologist.
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VANFLYTA
Drug Names	VANFLYTA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VENCLEXTA
Drug Names	VENCLEXTA, VENCLEXTA STARTING PACK
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Mantle cell lymphoma, blastic plasmacytoid dendritic cell neoplasm (BPDCN), multiple myeloma, relapsed or refractory acute myeloid leukemia (AML), Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, relapsed or refractory systemic light chain amyloidosis with translocation t(11:14), myelodysplastic syndrome
Exclusion Criteria	-
Required Medical Information	For acute myeloid leukemia (AML): 1) patient is 60 years of age or older, OR 2) patient is less than 60 years of age with unfavorable risk genetics and TP53-mutation, OR 3) patient has comorbidities that preclude use of intensive induction chemotherapy, OR 4) patient has relapsed or refractory disease. For blastic plasmacytoid dendritic cell neoplasm (BPDCN): 1) patient has systemic disease being treated with palliative intent, OR 2) patient has relapsed or refractory disease. For multiple myeloma: 1) the disease is relapsed or progressive, AND 2) the requested drug will be used in combination with dexamethasone, AND 3) patient has t(11:14) translocation. For Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma: 1) patient has previously treated disease that did not respond to primary therapy, OR 2) patient has progressive or relapsed disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VENTAVIS
Drug Names	VENTAVIS
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	VERSACLOZ
Drug Names	VERSACLOZ
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of a severely ill patient with schizophrenia who failed to respond adequately to standard antipsychotic treatment (i.e., treatment-resistant schizophrenia): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Rexulti, Secuado, Vraylar.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VERZENIO
Drug Names	VERZENIO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer in combination with fulvestrant or an aromatase inhibitor, or as a single agent if progression on prior endocrine therapy and prior chemotherapy in the metastatic setting.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VICTOZA
Drug Names	VICTOZA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	The Prior Authorization only applies to patients whose claim is not submitted with an ICD-10 code indicating a diagnosis of type 2 diabetes mellitus OR to patients who do not have a history of an antidiabetic drug (EXCLUDING glucagon-like peptide receptor agonists [GLP-1 RAs] and combination glucose-dependent insulinotropic polypeptide [GIP] and GLP-1 RAs).

Prior Authorization Group	VIGABATRIN
Drug Names	VIGABATRIN, VIGADRONE, VIGPODER
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For complex partial seizures (i.e., focal impaired awareness seizures): patient has experienced an inadequate treatment response to at least two antiepileptic drugs for complex partial seizures (i.e., focal impaired awareness seizures).
Age Restrictions	Infantile Spasms: 1 month to 2 years of age. Complex partial seizures (i.e., focal impaired awareness seizures): 2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VIJOICE
Drug Names	VIJOICE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VITRAKVI
Drug Names	VITRAKVI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-metastatic neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors.
Exclusion Criteria	-
Required Medical Information	For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, the disease is without a known acquired resistance mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VIZIMPRO
Drug Names	VIZIMPRO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer (NSCLC).
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced or metastatic, and 2) the patient has sensitizing EGFR mutation-positive disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VONJO
Drug Names	VONJO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VORICONAZOLE
Drug Names	VORICONAZOLE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient will use the requested drug orally or intravenously.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	VOSEVI
Drug Names	VOSEVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	For hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	-

Prior Authorization Group	VOTRIENT
Drug Names	PAZOPANIB HYDROCHLORIDE, VOTRIENT
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma, chondrosarcoma, gastrointestinal stromal tumor
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma: 1) The disease is advanced, relapsed, or stage IV, OR 2) the requested drug will be used for von Hippel-Lindau (VHL)-associated renal cell carcinoma. For gastrointestinal stromal tumor (GIST): the patients meets one of the following: 1) the disease is unresectable, recurrent/progressive, or metastatic AND the patient has failed an FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib), 2) the requested drug will be used for unresectable succinate dehydrogenase (SDH)-deficient GIST, OR 3) the requested drug will be used for the palliation of symptoms if previously tolerated and effective. For soft tissue sarcoma (STS): The patient does not have an adipocytic soft tissue sarcoma. For uterine sarcoma: The disease is recurrent or metastatic.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VOWST
Drug Names	VOWST
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the prevention of recurrence of Clostridioides difficile infection (CDI): 1) The diagnosis of CDI has been confirmed by a positive stool test for C. difficile toxin, AND 2) The requested drug will be administered at least 48 hours after the last dose of antibiotics used for the treatment of recurrent CDI.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-

Prior Authorization Group	VYNDAMAX
Drug Names	VYNDAMAX
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cardiomyopathy of hereditary or wild-type transthyretin-mediated amyloidosis (ATTR-CM): Initiation: 1) patient exhibits clinical manifestation of disease (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema), AND 2) cardiac involvement was confirmed by echocardiography or cardiac magnetic resonance imaging (e.g., end-diastolic interventricular septal wall thickness exceeding 12 millimeters), AND 3) patient meets one of the following: a) if the request is for hereditary ATTR-CM the patient is positive for a mutation of the transthyretin (TTR) gene, b) if the request is for wild-type ATTR-CM the patient has transthyretin precursor proteins confirmed by testing. Continuation: patient demonstrates a beneficial response to therapy (e.g., slowing of clinical decline).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VYNDAQEL
Drug Names	VYNDAQEL
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For cardiomyopathy of hereditary or wild-type transthyretin-mediated amyloidosis (ATTR-CM): Initiation: 1) patient exhibits clinical manifestation of disease (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema), AND 2) cardiac involvement was confirmed by echocardiography or cardiac magnetic resonance imaging (e.g., end-diastolic interventricular septal wall thickness exceeding 12 millimeters), AND 3) patient meets one of the following: a) if the request is for hereditary ATTR-CM the patient is positive for a mutation of the transthyretin (TTR) gene, b) if the request is for wild-type ATTR-CM the patient has transthyretin precursor proteins confirmed by testing. Continuation: patient demonstrates a beneficial response to therapy (e.g., slowing of clinical decline).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	WELIREG
Drug Names	WELIREG
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	WINLEVI
Drug Names	WINLEVI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance or the patient has a contraindication to a generic acne product (e.g., topical clindamycin, topical erythromycin, topical retinoid, or oral isotretinoin).
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XALKORI
Drug Names	XALKORI
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent non-small cell lung cancer (NSCLC), NSCLC with high-level MET amplification or MET exon 14 skipping mutation, symptomatic or relapsed/refractory anaplastic lymphoma kinase (ALK)-fusion positive Erdheim-Chester Disease, symptomatic or relapsed/refractory (ALK)-fusion positive Rosai-Dorfman Disease, (ALK)-fusion positive Langerhans Cell Histiocytosis.
Exclusion Criteria	-
Required Medical Information	For NSCLC, the requested drug is used in any of the following settings: 1) the patient has recurrent, advanced or metastatic ALK-positive NSCLC, OR 2) the patient has recurrent, advanced or metastatic ROS-1 positive NSCLC, OR 3) the patient has NSCLC with high-level MET amplification or MET exon 14 skipping mutation. For IMT, the disease is ALK-positive. For ALCL, the disease is relapsed or refractory and ALK-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XELJANZ
Drug Names	XELJANZ, XELJANZ XR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]). For active psoriatic arthritis (new starts only): 1) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]) AND 2) the requested drug is used in combination with a nonbiologic DMARD. For active ankylosing spondylitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]). For moderately to severely active ulcerative colitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., Humira [adalimumab]). For active polyarticular course juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XERMELO
Drug Names	XERMELO
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XGEVA
Drug Names	XGEVA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For hypercalcemia of malignancy: condition is refractory to intravenous (IV) bisphosphonate therapy or there is a clinical reason to avoid IV bisphosphonate therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	XHANCE
Drug Names	XHANCE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Patient has experienced an inadequate treatment response to generic fluticasone nasal spray.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XIFAXAN
Drug Names	XIFAXAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For irritable bowel syndrome with diarrhea (IBS-D): 1) The patient has not previously received treatment with the requested drug OR 2) The patient has previously received treatment with the requested drug AND a) the patient is experiencing a recurrence of symptoms AND b) the patient has not already received an initial 14-day course of treatment and two additional 14-day courses of treatment with the requested drug.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Reduction in risk of overt HE recurrence: 6 Months, IBS-D: 14 Days
Other Criteria	-

Prior Authorization Group	XIFAXAN 200MG
Drug Names	XIFAXAN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Must have a documented diagnosis of Traveler's diarrhea caused by Noninvasive strains of E coli.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XOLAIR
Drug Names	XOLAIR
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For moderate to severe persistent asthma, initial therapy: 1) Patient has a positive skin test (or blood test) to at least one perennial aeroallergen, 2) Patient has baseline IgE level greater than or equal to 30 IU/mL, AND 3) Patient has inadequate asthma control despite current treatment with both of the following medications: a) Medium-to-high-dose inhaled corticosteroid, AND b) Additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For moderate to severe persistent asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For chronic spontaneous urticaria (CSU), initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (e.g., auto-inflammatory disorders, urticarial vasculitis), 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks, AND 3) Patient remains symptomatic despite H1 antihistamine treatment. For CSU, continuation of therapy: Patient has experienced a benefit (e.g., improved symptoms) since initiation of therapy. For chronic rhinosinusitis with nasal polyps (CRSwNP): 1) The requested drug is used as add-on maintenance treatment, AND 2) Patient has experienced inadequate treatment response to Xhance (fluticasone).
Age Restrictions	CSU: 12 years of age or older. Asthma: 6 years of age or older. CRSwNP: 18 years of age or older
Prescriber Restrictions	-
Coverage Duration	CSU initial: 6 months, All others: Plan Year
Other Criteria	-

Prior Authorization Group	XOSPATA
Drug Names	XOSPATA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FLT3 rearrangement
Exclusion Criteria	-
Required Medical Information	For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FMS-like tyrosine kinase 3 (FLT3) rearrangement: the disease is in chronic or blast phase.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XPOVIO
Drug Names	XPOVIO, XPOVIO 60 MG TWICE WEEKLY, XPOVIO 80 MG TWICE WEEKLY
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma, high-grade B-cell lymphoma
Exclusion Criteria	-
Required Medical Information	For multiple myeloma: Patient must have been treated with at least one prior therapy. For B-cell lymphomas: Patient must have been treated with at least two lines of systemic therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XTANDI
Drug Names	XTANDI
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of castration-resistant prostate cancer or metastatic castration-sensitive prostate cancer: The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XURIDEN
Drug Names	XURIDEN
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Must have a documented diagnosis of hereditary orotic aciduria.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XYREM
Drug Names	SODIUM OXYBATE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of excessive daytime sleepiness in a patient with narcolepsy, initial request: 1) The diagnosis has been confirmed by sleep lab evaluation, AND 2) The patient meets one of the following criteria: a) if the patient is 17 years of age or younger, the patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate), OR has a contraindication that would prohibit a trial of central nervous system (CNS) stimulant drugs (e.g., amphetamine, dextroamphetamine, methylphenidate), b) If the patient is 18 years of age or older, the patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil, modafinil). For the treatment of cataplexy in a patient with narcolepsy, initial request: The diagnosis has been confirmed by sleep lab evaluation. If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.
Age Restrictions	7 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XYWAV
Drug Names	XYWAV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of excessive daytime sleepiness in a patient (pt) with narcolepsy, initial request: 1) the diagnosis (dx) has been confirmed by sleep lab evaluation, AND 2) the pt meets one of the following criteria: a) If the pt is 17 years of age or younger, the pt has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate), OR has a contraindication that would prohibit a trial of CNS stimulant drugs (e.g., amphetamine, dextroamphetamine, methylphenidate), b) If the pt is 18 years of age or older, the pt has experienced an inadequate treatment response or intolerance to at least one CNS wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of CNS wakefulness promoting drugs (e.g., armodafinil, modafinil). For idiopathic hypersomnia the diagnosis has been confirmed by ALL of the following: 1) pt has experienced lapses into sleep or an irrepressible need to sleep during daytime, on a daily basis, for at least 3 months, AND 2) insufficient sleep syndrome is confirmed absent, AND 3) cataplexy is absent, AND 4) fewer than 2 sleep onset rapid eye movement periods (SOREMPs) or no SOREMPs, if the rapid eye movement latency on an overnight sleep study was less than or equal to 15 minutes, AND 5) average sleep latency of less than or equal to 8 minutes on Multiple Sleep Latency Test or total 24-hour sleep time is greater than or equal to 11 hours, AND 6) another condition (sleep disorder, medical or psychiatric disorder, or drug/medication use) does not better explain the hypersomnolence and test results.
Age Restrictions	Narcolepsy: 7 years of age or older, Idiopathic hypersomnia: 18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist
Coverage Duration	Plan Year
Other Criteria	For the treatment of cataplexy in a pt with narcolepsy, initial request: the dx has been confirmed by sleep lab evaluation. For narcolepsy, continuation of therapy: the pt has experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy. For idiopathic hypersomnia, continuation of therapy: the pt has experienced a decrease in daytime sleepiness from baseline.

Prior Authorization Group	YONSA
Drug Names	YONSA
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZARXIO
Drug Names	ZARXIO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia, neutropenia related to renal transplant, hematopoietic syndrome of acute radiation syndrome
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy.
Required Medical Information	For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN) patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, and 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	ZEJULA
Drug Names	ZEJULA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Uterine leiomyosarcoma
Exclusion Criteria	-
Required Medical Information	For uterine leiomyosarcoma: 1) the requested drug is used as second-line therapy AND 2) the patient has BRCA-altered disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZELBORAF
Drug Names	ZELBORAF
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Non-small cell lung cancer, hairy cell leukemia, thyroid carcinoma (i.e., papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), central nervous system cancer (i.e., glioma, astrocytoma, glioblastoma, pediatric diffuse high-grade glioma), adjuvant systemic therapy for cutaneous melanoma, Langerhans cell histiocytosis.
Exclusion Criteria	-
Required Medical Information	For central nervous system (CNS) cancer (i.e., glioma, astrocytoma, glioblastoma, pediatric diffuse high-grade glioma): 1) The tumor is positive for BRAF V600E mutation, AND 2) The requested drug will be used in combination with cobimetinib OR the requested drug is being used for the treatment of pediatric diffuse high-grade glioma. For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) the requested drug will be used as a single agent, or in combination with cobimetinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, or b) adjuvant systemic therapy. For Erdheim-Chester Disease and Langerhans Cell Histiocytosis: Tumor is positive for BRAF V600 mutation. For non-small cell lung cancer: 1) The tumor is positive for the BRAF V600E mutation, AND 2) The patient has recurrent, advanced, or metastatic disease. For papillary, follicular, and hurthle cell thyroid carcinoma: 1) The tumor is positive for BRAF mutation, AND 2) The disease is not amenable to radioactive iodine (RAI) therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZIEXTENZO
Drug Names	ZIEXTENZO
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Stem cell transplantation-related indications
Exclusion Criteria	Use of the requested product less than 24 hours before or after chemotherapy.
Required Medical Information	For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: the patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, and 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 months
Other Criteria	-

Prior Authorization Group	ZIRABEV
Drug Names	ZIRABEV
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Ampullary adenocarcinoma, breast cancer, central nervous system (CNS) cancers, malignant pleural mesothelioma, malignant peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	ZOLINZA
Drug Names	ZOLINZA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Mycosis fungoides (MF)/Sezary syndrome (SS)
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZONISADE
Drug Names	ZONISADE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For adjunctive treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri, Spritam OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	16 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZTALMY
Drug Names	ZTALMY
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZURZUVAE
Drug Names	ZURZUVAE
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	For the treatment of postpartum depression (PPD): diagnosis was confirmed using standardized rating scales that reliably measure depressive symptoms (e.g., Hamilton Depression Rating Scale [HDRS], Edinburgh Postnatal Depression Scale [EPDS], Patient Health Questionnaire 9 [PHQ9], Montgomery-Asberg Depression Rating Scale [MADRS], Beck's Depression Inventory [BDI], etc.).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 month
Other Criteria	-

Prior Authorization Group	ZYDELIG
Drug Names	ZYDELIG
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Small lymphocytic lymphoma (SLL)
Exclusion Criteria	-
Required Medical Information	For CLL/SLL: the requested drug is used as second-line or subsequent therapy
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZYKADIA
Drug Names	ZYKADIA
PA Indication Indicator	All FDA-approved Indications, Some Medically-accepted Indications
Off-label Uses	Recurrent ALK-positive non-small cell lung cancer (NSCLC), recurrent, advanced, or metastatic ROS1-positive NSCLC, inflammatory myofibroblastic tumor (IMT), brain metastases from NSCLC.
Exclusion Criteria	-
Required Medical Information	For NSCLC: the patient has recurrent, advanced, or metastatic ALK-positive or ROS1-positive disease. For inflammatory myofibroblastic tumor: the disease is ALK-positive. For brain metastases from NSCLC: the patient has ALK-positive NSCLC.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZYPREXA RELPREVV
Drug Names	ZYPREXA RELPREVV
PA Indication Indicator	All FDA-approved Indications
Off-label Uses	-
Exclusion Criteria	-
Required Medical Information	Tolerability with oral olanzapine has been established.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-